Research Data Distribution Center
LDS Hospice Claim Record
Data Dictionary

Variable Name	*Label*

CLAIM_NO

CLAIM NUMBER
The unique number used to identify a unique claim.
SAS ALIAS: CLAIM_NO
STANDARD ALIAS: CLAIM_NO

DSYSRTKY

DESY SORT KEY
This field contains the key to link data for each beneficiary across all claim files.
SAS ALIAS: DSYSRTKY
STANDARD ALIAS: DESY_SORT_KEY

REC_LVL

NCH Near-Line Record Version Code
The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored:

DB2 ALIAS: NCH_REC_VRSN_CD
SAS ALIAS: REC_LVL
STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD
TITLE ALIAS: NCH_VERSION

CODES:
A = Record format as of January 1991
B = Record format as of April 1991
C = Record format as of May 1991
D = Record format as of January 1992
E = Record format as of March 1992
F = Record format as of May 1992
G = Record format as of October 1993
H = Record format as of September 1998
I = Record format as of July 2000

RIC_CD

NCN Near Line Record Identification Code
A code defining the type of claim record being processed.
COMMON ALIAS: RIC

DBS ALAIS: NEAR_LINE_RIC_CD
SAS ALIAS: RIC_CD

CODES;
REFER TO: NCH_NEAR_LINE_RIC_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CLM_NEAR_LINE_REC_VRSN_CD

SOURCE:
NCH

CLM_TYPE

NCH Claim Type Code
The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was
populated with data through-out history (back to
service year 1991).

NOTE2: During the Version I conversion this field was
expanded to include inpatient 'full' encounter
claims (for service dates after 6/30/97).
Placeholders for Physician and Outpatient encounters
(available in NMUD) have also been added.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: UTLHOSPI_NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPE
TITLE ALIAS: CLAIM_TYPE
DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
NCH CLM_NEAR_LINE_RIC_CD
NCH PMT_EDIT_RIC_CD
NCH CLM_TRANS_CD
NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED
FROM:
(Pre-HDC processing -- AVAILABLE IN
NCH) CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED
FROM:
(HDC processing -- AVAILABLE IN NMUD)
FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE
CODE DERIVED
FROM: (HDC processing -- AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD
NOTE: From 7/1/97 to the start of HDC processing(?),
abbreviated inpatient encounter claims are not
available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE
DERIVED FROM:
(AVAILABLE IN NMUD)
CARR_NUM
CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE
DERIVED FROM:
(AVAILABLE IN NMUD)
FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE

Variable Name	*Label*	

DERIVED FROM: (AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED
CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W',
'Y' OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8';
CLM_SRVC_ CLSFCTN_TYPE_CD = '2', '3' OR '4'
& CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL'
ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97
- 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE

MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN
THE MCO_PRD_EFCTV_DT &
MCO_PRD_TRMNTN_DT ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL'
ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE
THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one
or more line item(s) match the HCPCS on the
DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER
CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING
CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS
CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC
CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one
or more line item(s) match the HCPCS on the
DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

Variable Name	Label

STATE_CD   **Beneficiary Residence SSA Standard State Code**

The SSA standard state code of a beneficiary's residence.
DA3 ALIAS: SSA_STANDARD_STATE_CODE DB2
ALIAS: BENE_SSA_STATE_CD
SAS ALIAS: STATE_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

COMMENT:
1. Used in conjunction with a county code,
as selection criteria for the determination of
payment rates for HMO reimbursement.
2. Concerning individuals directly billable for
Part B and/or Part A premiums, this element
is used to determine if the beneficiary
will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE:
SSA/EDB

THRU_DT   **Claim Through Date**

The last day on the billing statement covering
services rendered to the beneficiary (a.k.a
'Statement Covers Thru Date').

For the ENCRYPTED Standard View of
the Hospice files, the claim through date is
coded as when the claim through date
occurred.

NOTE: For Home Health PPS claims, the 'from'
date and the 'thru' date on the RAP (initial
claim) must always match.
8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT
SAS ALIAS: THRU_DT
STANDARD ALIAS: CLM_THRU_DT
TITLE ALIAS: THRU_DATE

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCYY
REPRESENTS THE YEAR.

SOURCE:
CWF

Variable Name	Label

QUERY_CD *Claim Query Code*

Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).

DB2 ALIAS: CLM_QUERY_CD
SAS ALIAS: QUERY_CD
STANDARD ALIAS: CLM_QUERY_CD
TITLE ALIAS: QUERY_CD

CODES:
0 = Credit adjustment
1 = Interim bill
2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98)
3 = Final bill
4 = Discharge notice (obsolete 7/98)
5 = Debit adjustment

SOURCE:
CWF

PROVIDER *Provider Number*

The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

DB2 ALIAS: PRVDR_NUM
SAS ALIAS: PROVIDER
STANDARD ALIAS: PRVDR_NUM
TITLE ALIAS: PROVIDER_NUMBER

CODES:
REFER TO: PRVDR_NUM_TB
IN THE CODES APPENDIX
SOURCE:
OSCAR

SGMT_CNT *Claim Total Segment Count*

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.
2 DIGITS UNSIGNED
DB2 ALIAS: TOT_SGMT_CNT
SAS ALIAS: SGMT_CNT
STANDARD ALIAS: CLM_TOT_SGMT_CNT TITLE ALIAS: SEGMENT_COUNT SOURCE:
CWF

Variable Name	Label

SGMT_NUM *Claim Segment Number*

Effective with Version I, the number used to identify an
actual record/segment (1 - 10)
associated with a given claim.
NOTE: During the Version I conversion this
field was populated with data throughout
history (back to service year 1991).
For institutional claims prior to 7/00,
this number will be either 1 or 2. For
noninstitutional claims, the number
will always be 1.
2 DIGITS UNSIGNED
DB2 ALIAS: CLM_SGMT_NUM
SAS ALIAS: SGMT_NUM
STANDARD ALIAS:
CLM_SGMT_NUM TITLE ALIAS:
SEGMENT_NUMBER SOURCE:
CWF

PE_RIC *NCH Payment and Edit Record Identification Code*

The code used for payment and editing purposes
that indicates the type of institutional claim record.
DB2 ALIAS: PMT_EDIT_RIC_CD
SAS ALIAS: PE_RIC
STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD
TITLE ALIAS: NCH_PAYMENT_EDIT_RIC

CODES:
C = Inpatient hospital, SNF
D = Outpatient
E = Religious Nonmedical Health Care Institutions
(eff. Christian Science, prior to 7/00
F = Home Health Agency
(HHA) G = Discharge notice
(obsoleted 7/98)
I = Hospice

COMMENT:
Prior to Version H this field was named:
PMT_EDIT_RIC_CD.

SOURCE:
NCH QA Process

TRANS_CD *Claim Transaction Code*

The code derived by CWF to indicate the type of claim
submitted by an institutional provider.

DB2 ALIAS: CLM_TRANS_CD
SAS ALIAS: TRANS_CD
STANDARD ALIAS: CLM_TRANS_CD
SYSTEM ALIAS: LTCLTRAN
TITLE ALIAS: TRANSACTION_CODE

CODES:
REFER TO: CLM_TRANS_TB
IN THE CODES APPENDIX

SOURCE:
CWF

Variable Name	Label

FAC_TYPE   *Claim Facility Type Code*

> The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.
>
> COMMON ALIAS: TOB1
> DB2 ALIAS: CLM_FAC_TYPE_CD
> SAS ALIAS: FAC_TYPE
> STANDARD ALIAS: CLM_FAC_TYPE_CD
> TITLE ALIAS: TOB1
> CODES:
> REFER TO: CLM_FAC_TYPE_TB
> IN THE CODES APPENDIX
>
> SOURCE:
> CWF

TYPESRVC   *Claim Service Classification Type Code*

> The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification ofthe type of service provided to the beneficiary.
>
> COMMON ALIAS: TOB2
> DB2 ALIAS: SRVC_CLSFCTN_CD
> SAS ALIAS: TYPESRVC
> STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
> TITLE ALIAS: TOB2
>
> CODES:
> REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
> IN THE CODES APPENDIX
>
> SOURCE:
> CWF

FREQ_CD   *Claim Frequency Code*

> The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.
> COMMON ALIAS: TOB3
> DB2 ALIAS: CLM_FREQ_CD
> SAS ALIAS: FREQ_CD
> STANDARD ALIAS: CLM_FREQ_CD
> SYSTEM ALIAS: LTFREQ
> TITLE ALIAS: FREQUENCY_CD
>
> CODES:
> REFER TO: CLM_FREQ_TB
> IN THE CODES APPENDIX
>
> SOURCE:
> CWF

CNTY_CD   *Beneficiary Residence SSA Standard County Code*

> The SSA standard county code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
> DB2 ALIAS: BENE_SSA_CNTY_CD
> SAS ALIAS: CNTY_CD
> STANDARD ALIAS:
> TITLE ALIAS: BENE_COUNTY_CD
>
> EDIT-RULES:
> OPTIONAL: MAY BE BLANK
>
> SOURCE: SSA/EDB

Variable Name	*Label*

FI_NUM   *FI Number*

The identification number assigned by HCFA to a fiscal intermediary authorized to process institutional claim records.

DB2 ALIAS: FI_NUM
SAS ALIAS: FI_NUM
STANDARD ALIAS: FI_NUM
SYSTEM ALIAS: LTFI
TITLE ALIAS: INTERMEDIARY

CODES:
REFER TO: FI_NUM_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
FICARR_IDENT_NUM.

SOURCE:
CWF

SEX   *Beneficiary Sex Identification Code*

The sex of a beneficiary. COMMON ALIAS:
SEX_CD DA3 ALIAS: SEX_CODE
DB2 ALIAS: BENE_SEX_IDENT_CD
SAS ALIAS: SEX
STANDARD ALIAS: BENE_SEX_IDENT_CD
SYSTEM ALIAS: LTSEX
TITLE ALIAS: SEX_CD

EDIT-RULES:
REQUIRED FIELD

CODES:
1 = Male
2 = Female
0 = Unknown

SOURCE:
SSA,RRB,EDB

RACE   *Beneficiary Race Code*

The race of a beneficiary. DA3
ALIAS: RACE_CODE DB2
ALIAS: BENE_RACE_CD
SAS ALIAS: RACE
STANDARD ALIAS: BENE_RACE_CD
SYSTEM ALIAS: LTRACE
TITLE ALIAS: RACE_CD

CODES:
0 = Unknown
1 = White
2 = Black
3 = Other
4 = Asian
5 = Hispanic
6 = North American Native

SOURCE:
SSA

Variable Name	Label
BENE_DOB	*Beneficiary Birth Date*

The beneficiary's date of birth.
For the ENCRYPTED Standard View of
the Hospice files, the beneficiary's
date of birth (age) is coded as a range.

8 DIGITS UNSIGNED

DB2 ALIAS: BENE_BIRTH_DT
SAS ALIAS: BENE_DOB
STANDARD ALIAS: BENE_BIRTH_DT
TITLE ALIAS: BENE_BIRTH_DATE

EDIT-RULES FOR ENCRYPTED DATA:
0000000R
WHERE R HAS ONE OF THE FOLLOWING VALUES.
0 = Unknown
1 = <65
2 = 65 Thru 69
3 = 70 Thru 74
4 = 75 Thru 79
5 = 80 Thru 84
6 = >84

SOURCE:
CWF

Variable Name	Label
MS_CD	*CWF Beneficiary Medicare Status Code*

The CWF-derived reason for a beneficiary's entitlement
to Medicare benefits, as of the reference date
(CLM_THRU_DT).

COBOL ALIAS: MSC
COMMON ALIAS: MSC
DB2 ALIAS: BENE_MDCR_STUS_CD
SAS ALIAS: MS_CD
STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
SYSTEM ALIAS: LTMSC
TITLE ALIAS: MSC

DERIVATION:
CWF derives MSC from the following:
1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number
Items 1,3,4,5 come from the CWF Beneficiary
Master Record; item 2 comes from the FI/Carrier
claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

CODES:
10 = Aged without ESRD
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD only

Variable Name	*Label*

COMMENT:
Prior to Version H this field was named:
BENE_MDCR_STUS_CD. The name has been changed
to distinguish this CWF-derived field from the EDB-
derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

PDGNS_CD　　　　　　*Claim Principal Diagnosis Code*

The ICD-9-CM diagnosis code identifying the
diagnosis, condition, problem or other reason for the
admission/encounter/visit shown in the medical record
chiefly responsible for the services provided.

NOTE: Effective with Version H, this data is also
redundantly stored as the first occurrence of the
diagnosis trailer.

DB2 ALIAS: PRNCPAL_DGNS_CD
SAS ALIAS: PDGNS_CD
STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
TITLE ALIAS: PRINCIPAL_DIAGNOSIS

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

NOPAY_CD　　　　　　*Claim Medicare Non Payment Reason Code*

The reason that no Medicare payment is made for
services on an institutional claim.
NOTE: Effective with Version I, this field was
put on all institutional claim types.
Prior to Version I, this field was present
only on inpatient/SNF claims.
DB2 ALIAS: MDCR_NPMT_RSN_CD
SAS ALIAS: NOPAY_CD
STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
SYSTEM ALIAS: LTNPMT
TITLE ALIAS: NON_PAYMENT_REASON

EDIT-RULES:
OPTIONAL

CODES:
REFER TO: CLM_MDCR_NPMT_RSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

Variable Name	*Label*

TRTMT_CD   *Claim Excepted/Non-Excepted Medical Treatment Code*

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is re-quired under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS: EXCPTD_NEXCPTD_CD
SAS ALIAS: TRTMT_CD
STANDARD ALIAS: TITLE ALIAS: EXCPTD_NEXCPTD_CD

CODES:
0 = No Entry
1 = Excepted
2 = Nonexcepted

SOURCE:
CWF

PMT_AMT   *Claim Payment Amount*

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid daily per diem rate no matter what the charges are.) Under IP PPS, inpatient hospital services are paid based a predetermined rate per discharge, using the DRG classification system and the PRICER program. On the PPS claim, the payment amount includes the DRG approved payment amount, disproportionate share 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount. Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage adjustment and the beneficiary deductible and amounts. NOTE: There is no CWF edit check to validate the revenue center Medicare payment amount equals the claim level Medicare payment amount.

Under Home Health PPS, beneficiaries will be classified an appropriate case mix category known as the Home Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case episode payment. The payment is then wage index
For the final claim, PRICER calculates 100% of the due, because the final claim is processed as an
to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: CLM_PMT_AMT
SAS ALIAS: PMT_AMT
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was S9(7)V99. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE:
CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the

Variable Name	Label

reimbursement reported on the claims may be over or under the actual Medicare payment amount.

PRPAYAMT   *NCH Primary Payer Claim Paid Amount*

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that theprovider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.

9.2 DIGITS SIGNED

DB2 ALIAS: PRMRY_PYR_PD_AMT
SAS ALIAS: PRPAYAMT
STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT
TITLE ALIAS: PRIMARY_PAYER_AMOUNT

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H this field was named:
BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99.

SOURCE:
NCH

PRPAY_CD   *NCH Primary Payer Code*

The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills.

DB2 ALIAS: NCH_PRMRY_PYR_CD
SAS ALIAS: PRPAY_CD
STANDARD ALIAS: NCH_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE CLM_VAL_CD = '12'

SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE CLM_VAL_CD = '13'

SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14'

SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15'

SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT not equal to zeroes)

SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43'

Variable Name	*Label*	

SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM_VAL_CD = '41'

SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE CLM_VAL_CD = '42'

SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97 set code to 'J') WHERE THE CLM_VAL_CD = '47'

CODES:
REFER TO: BENE_PRMRY_PYR_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
BENE_PRMRY_PYR_CD.

SOURCE:
NCH

CANCELCD — *FI Requested Claim Cancel Reason Code*

The reason that an intermediary requested cancelling a previously submitted institutional claim. DB2 ALIAS: RQST_CNCL_RSN_CD
SAS ALIAS: CANCELCD
STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD
TITLE ALIAS: CANCEL_CD

CODES:
REFER TO: FI_RQST_CLM_CNCL_RSN_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
INTRMDRY_RQST_CLM_CNCL_RSN_CD.

SOURCE:
CWF

ACTIONCD — *FI Claim Action Code*

The type of action requested by the intermediary to be taken on an institutional claim.
DB2 ALIAS: FI_CLM_ACTN_CD
SAS ALIAS: ACTIONCD
STANDARD ALIAS: FI_CLM_ACTN_CD
TITLE ALIAS: ACTION_CD
CODES:
REFER TO: FI_CLM_ACTN_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
INTRMDRY_CLM_ACTN_CD.

SOURCE:
CWF

Variable Name	Label

PRSTATE   *NCH Provider State Code*

Effective with Version H, the two position SSA state code where provider facility is located.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service 1991).

DB2 ALIAS: NCH_PRVDR_STATE_CD
SAS ALIAS: PRSTATE
STANDARD ALIAS: NCH_PRVDR_STATE_CD
TITLE ALIAS: PROVIDER_STATE_CD

DERIVATION:
DERIVED FROM:
NCH PRVDR_NUM

DERIVATION RULES:

SET NCH_PRVDR_STATE_CD TO
PRVDR_NUM POS1-2.
FOR PRVDR_NUM POS1-2 EQUAL '55
SET NCH_PRVDR_STATE_CD TO '05'.
FOR PRVDR_NUM POS1-2 EQUAL '67
SET NCH_PRVDR_STATE_CD TO '45'.
FOR PRVDR_NUM POS1-2 EQUAL '68
SET NCH_PRVDR_STATE_CD TO '10'.

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

AT_UPIN   *Claim Attending Physician UPIN Number*

On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

This field is ENCRYPTED for the ENCRYPTED Standard View of the Hospice files.

COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
DB2 ALIAS: ATNDG_UPIN
SAS ALIAS: AT_UPIN
STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
TITLE ALIAS: ATTENDING_PHYSICIAN

COMMENT:
Prior to Version H this field was named:
CLM_PRMRY_CARE_PHYSN_IDENT_NUM and
10 positions (6-position UPIN and 4-position physician surname).

SOURCE:
CWF

Variable Name	*Label*

OP_UPIN   *Claim Operating Physician UPIN Number*

On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.

This field is ENCRYPTED for the ENCRYPTED Standard View of the Hospice files.

DB2 ALIAS: OPRTG_UPIN
SAS ALIAS: OP_UPIN
STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM
TITLE ALIAS: OPRTG_UPIN

COMMENT:
Prior to Version H this field was named:
CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position physician surname.

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE:
CWF

OT_UPIN   *Claim Other Physician UPIN Number*

On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.

This field is ENCRYPTED for the ENCRYPTED Standard View of the Hospice files.

DB2 ALIAS: OTHR_UPIN
SAS ALIAS: OT_UPIN
STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
TITLE ALIAS: OTH_PHYSN_UPIN
COMMENT:
Prior to Version H this field was named:
CLM_OTHR_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname).

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE:
CWF

Variable Name	Label
MCOPDSW	*Claim MCO Paid Switch*

A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.

COBOL ALIAS: MCO_PD_IND
DB2 ALIAS: CLM_MCO_PD_SW
SAS ALIAS: MCOPDSW
STANDARD ALIAS: CLM_MCO_PD_SW
TITLE ALIAS: MCO_PAID_SW

CODES:
1 = MCO has paid the provider for a claim
Blank or 0 = MCO has not paid the
provider for a claim
COMMENT:
Prior to Version H this field was named:
CLM_GHO_PD_SW.

SOURCE:
CWF

STUS_CD	*Patient Discharge Status Code*

The code used to identify the status of the patient as of the CLM_THRU_DT.
COMMON ALIAS:
DISCHARGE_DESTINATION/PATIENT_STATUS
DB2 ALIAS: PTNT_DSCHRG_STUS
SAS ALIAS: STUS_CD
STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
SYSTEM ALIAS: LTCLMST
TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:
REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CLM_STUS_CD.

SOURCE:
CWF

DGNS_E	*Claim Diagnosis E Code*

Effective with Version H, the ICD-9- CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly this field is also stored as the last occurrence of the diagnosis trailer.

NOTE: During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history.

DB2 ALIAS: CLM_DGNS_E_CD
SAS ALIAS: DGNS_E
STANDARD ALIAS: CLM_DGNS_E_CD
TITLE ALIAS: DGNS_E_CD

SOURCE:
CWF

Variable Name	Label

PPS_IND   *Claim PPS Indicator Code*

Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was pop-ulated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

COBOL ALIAS: PPS_IND
DB2 ALIAS: CLM_PPS_IND_CD
SAS ALIAS: PPS_IND
STANDARD ALIAS: CLM_PPS_IND_CD
TITLE ALIAS: PPS_IND

CODES:
REFER TO: CLM_PPS_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

TOT_CHRG   *Claim Total Charge Amount*

Effective with Version G, the total charges for all services included on the institutional claim.
This field is redundant with revenue center code 0001/total charges.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_TOT_CHRG_AMT
SAS ALIAS: TOT_CHRG
STANDARD ALIAS: CLM_TOT_CHRG_AMT
TITLE ALIAS: CLAIM_TOTAL_CHARGES

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was S9(7)\V99.

SOURCE:
CWF

HSDGNCNT   *Hospice Claim Diagnosis Code Count*

The count of the number of diagnosis codes (both principal and other) reported on a hospice claim. The purpose of this count is to indicate how many claim trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: HOSPC_DGNS_CD_CNT
SAS ALIAS: HSDGNCNT
STANDARD ALIAS: HOSP_CLM_DGNS_CD_CNT

EDIT-RULES:
RANGE: 0 TO 10

Variable Name	Label

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD_CNT and the principal was
not included in the count.

SOURCE:
NCH

HSPRCNT   *Hospice Claim Procedure Code Count*

The count of the number of procedure codes (both
principal and other) reported on a hospice claim.
The purpose of this count is to indicate how
many claim procedure trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: HOSPC_PRCDR_CD_CNT
SAS ALIAS: HSPRCNT
STANDARD ALIAS: HOSPC_CLM_PRCDR_CD_CNT

EDIT-RULES:
RANGE: 0 TO 6

COMMENT:
Prior to Version H this field was named:
CLM_PRCDR_CD_CNT

SOURCE:
CWF

HSCONCNT   *Hospice Claim Related Condition Code Count*

The count of the number of condition codes reported
on a hospice claim. The purpose of this count is to
indicate how many condition code trailers are present.

2 DIGITS UNSIGNED
DB2 ALIAS: HOSPC_COND_CD_CNT
SAS ALIAS: HSCONCNT
STANDARD ALIAS: HOSPC_CLM_RLT_COND_CD_CNT

EDIT-RULES:
RANGE: 0 TO 30

COMMENT:
Prior to Version H this field was named:
CLM_RLT_COND_CD_CNT.

SOURCE:
NCH

HSOCRCNT   *Hospice Claim Related Occurrence Code Count*

The count of the number of occurrence codes reported
on a hospice claim. The purpose of this count is to
indicate how many occurrence code trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: HOSPC_RLT_OCRNC_CNT
SAS ALIAS: HSOCRCNT
STANDARD ALIAS:

EDIT-RULES:
RANGE: 0 TO 30

Variable Name	Label

COMMENT:
Prior to Version H this field was named:
CLM_RLT_OCRNC_CD_CNT.

SOURCE:
NCH

HSVALCNT   *Hospice Claim Value Code Count*

The count of the number of value codes reported on a
hospice claim. The purpose of the count is to indicate
how many value code trailers are
present.
2 DIGITS UNSIGNED

DB2 ALIAS: HOSPC_VAL_CD_CNT
SAS ALIAS: HSVALCNT
STANDARD ALIAS: HOSPC_CLM_VAL_CD_CNT

EDIT-RULES:
RANGE: 0 TO 36

COMMENT:
Prior to Version H this field was named:
CLM_VAL_CD_CNT.

SOURCE:
NCH

HSREVCNT   *Hospice Revenue Center Code Count*

The count of the number of revenue codes reported on a
hospice claim. The purpose of the count is to indicate
how many
revenue center trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: HOSPC_REV_CNTR_CD_CNT
SAS ALIAS: HSREVCNT
STANDARD ALIAS: HOSPC_REV_CNTR_CD_I_CNT

EDIT-RULES:
RANGE: 0 TO 45

COMMENT:
Prior to Version H this field was
named: CLM_REV_CNTR_CD_CNT.

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).

SOURCE:
NCH

Variable Name	Label

PTNTSTUS   **NCH Patient Status Indicator Code**

Effective with Version H, the code on an Inpatient/SNF
and Hospice claim, indicating whether the beneficiary
was discharged, died,
or still a patient (used for internal CWFMQA
editing purposes.)
NOTE: During the Version H conversion this
field was populated throughout history (back
to service year 1991).

DB2 ALIAS: NCH_PTNT_STUS_IND
SAS ALIAS: PTNTSTUS
STANDARD ALIAS: NCH_PTNT_STUS_IND_CD
TITLE ALIAS: NCH_PATIENT_STUS

DERIVATION RULES:
SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE
PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20' - '30'
OR '40' - '42'.

SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE
PTNT_DSCHRG_STUS_CD EQUAL TO '20' - '29'
OR '40' - '42.
SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE
THE PTNT_DSCHRG_STUS_CD EQUAL TO '30'.

CODES:
A = Discharged
B = Died
C = Still patient

SOURCE:
NCH QA Process

HSPCSTRT   **Claim Hospice Start Date**

On an institutional claim, the date the beneficiary was
admitted to the hospice.

For the ENCYRYPTED Standard View of the Hospice
files, the claim hospice start date is coded
as the quarter of the calendar year when the
claim hospice start date occurred.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_HOSPC_STRT_DT
SAS ALIAS: HSPCSTRT
STANDARD ALIAS: CLM_HOSPC_STRT_DT
TITLE ALIAS: HOSPC_START_DT

EDIT-RULES FOR ENCRYPTED DATA:
YYYYQ000 WHERE Q IS ONE OF
THE FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

COMMENT:
Prior to Version H, this field was named:
CLM_ADMSN_DT

SOURCE:
CWF

Variable Name	Label

DSCHRGDT   *NCH Beneficiary Discharge Date*

Effective with Version H, on an inpatient and Hospice claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.)

For the ENCRYPTED Standard View of the Hospice files, the beneficiary's discharge date is coded as the when the discharge occurred.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991.)

8 DIGITS UNSIGNED
DB2 ALIAS: NCH_BENE_DSCHRG_DT
SAS ALIAS: DSCHRGDT
STANDARD ALIAS: NCH_BENE_DSCHRG_DT
TITLE ALIAS: DISCHARGE_DT

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCYY
REPRESENTS THE YEAR.

DERIVATION:
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

DERIVATION RULES:
Based on the presence of patient discharge status code not equal to 30 (still patient), move the claim thru date to the NCH_BENE_DSCHRG_DT.

SOURCE:
NCH QA Process

UTIL_DAY   *Claim Utilization Day Count*

On an insitutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days.

3 DIGITS SIGNED

DB2 ALIAS: CLM_UTLZTN_DAY_CNT
SAS ALIAS: UTIL_DAY
STANDARD ALIAS: CLM_UTLZTN_DAY_CNT
TITLE ALIAS: UTILIZATION_DAYS

EDIT -
RULES: +999

SOURCE:
CWF

Variable Name	*Label*

HOSPCPRD *Beneficiary's Hospice Period Count*

The count of the number of hospice period trailers present for the beneficiary's record. Prior to BBA a entitled to a maximum of 4 hospice benefit periods that may be elected in lieu of standard Part A hospital benefits. The BBA changed the hospice benefit to the following: 2 initial 90 day periods followed by an unlimited number of 60 day periods (effective 8/5/97).

1 DIGIT UNSIGNED
DB2 ALIAS: BENE_HOSPC_PRD_CNT
SAS ALIAS: HOSPCPRD
STANDARD ALIAS: BENE_HOSPC_PRD_CNT
TITLE ALIAS: HOSPICE_PERIOD_COUNT

EDIT-RULES:
RANGE: 1 THRU 3: 1 = 1st 90-day period; 2=2nd 90 -day period and 3 = 3rd 90-day period (3 or greater periods)

SOURCE:
CWF

DGNSCD{x} *Claim Diagnosis Code*

where { x } ranges from 1 to 10

The ICD -9- CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

DB2 ALIAS: CLM_DGNS_CD
SAS ALIAS: DGNSCD{x}
STANDARD ALIAS: CLM_DGNS_CD
TITLE ALIAS: DIAGNOSIS

EDIT-RULES:
ICD-9-CM

COMMENT:
Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

PRCDRCD{x} *Claim Procedure Code*

where { x } ranges from 1 to 6

The ICD-9 -CM code that indicates the principal or other procedure performed during the period covered by the institutional claim.

DB2 ALIAS: CLM_PRCDR_CD
SAS ALIAS: PRCDRCD{x}
STANDARD ALIAS: CLM_PRCDR_CD
TITLE ALIAS: PROCEDURE_CODE

EDIT-RULES:
ICD-9-CM

SOURCE: CWF

Variable Name	Label
PRCDRDT{x}	*Claim Procedure Performed Date*

where { x } ranges from 1 to 6

On an institutional claim, the date on which the principal or other procedure was performed. For the ENCRYPTED Standard View of the Hospice files, the claim procedure performed date is coded as when the procedure was performed.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_PRCDR_PRFRM_DT
SAS ALIAS: PRCDRDT{x}
STANDARD ALIAS: CLM_PRCDR_PRFRM_DT
TITLE ALIAS: PROCEDURE_DATE

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCYY
REPRESENTS THE YEAR.

SOURCE:
CWF

RLTCND{x}	*Claim Related Condition Code*

where { x } ranges from 1 to 30

The code that indicates a condition relating to an institutional claim that may affect payer processing.

DB2 ALIAS: CLM_RLT_COND_CD
SAS ALIAS: RLTCND{x}
STANDARD ALIAS: CLM_RLT_COND_CD
SYSTEM ALIAS: LTCOND
TITLE ALIAS: RELATED_CONDITION_CD

CODES:
01 THRU 16 = Insurance related
17 THRU 30 = Special condition
31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old
36 THRU 45 = Accommodation
46 THRU 54 = CHAMPUS information
55 THRU 59 = Skilled nursing facility
60 THRU 70 = Prospective payment
71 THRU 99 = Renal dialysis setting
A0 THRU B9 = Special program codes

C0 THRU C9 = PRO approval services
D0 THRU W0 = Change conditions

CODES:
REFER TO: CLM_RLT_COND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

Variable Name	Label

OCRCCD{x}   *Claim Related Occurrence Code*

where { x } ranges from 1 to 30

The code that identifies a significant event relating to
an institutional claim that may affect payer processing.
These codes are
claim-related occurrences that are related
to a specific date.

DB2 ALIAS: CLM_RLT_OCRNC_CD
SAS ALIAS: OCRCCD{x}
STANDARD ALIAS: CLM_RLT_OCRNC_CD
SYSTEM ALIAS: LTOCRNC
TITLE ALIAS: OCCURRENCE_CD

CODES:
01 THRU 09 = Accident
10 THRU 19 = Medical condition
20 THRU 39 = Insurance related
40 THRU 69 = Service related
A1-A3 = Miscellaneous

CODES:
REFER TO: CLM_RLT_OCRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

OCRCDT{x}   *Claim Related Occurrence Date*

where { x } ranges from 1 to 30

The date associated with a significant event related to
an institutional claim that may affect payer processing.

For the ENCRYPTED Standard View of
the Hospice files, the claim related
occurrence date is coded as when the
claim related occurrence occurred.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_RLT_OCRNC_DT
SAS ALIAS: OCRCDT{x}
STANDARD ALIAS: CLM_RLT_OCRNC_DT
TITLE ALIAS: RLT_OCRNC_DT

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCYY
REPRESENTS THE YEAR.

SOURCE:
CWF

Variable Name	Label

VAL_CD{x}
where { x } ranges from 1 to 36

Claim Value Code

> The code indicating the value of a monetary
> condition which was used by the intermediary
> to process an institutional claim.
> DB2 ALIAS: CLM_VAL_CD
> SAS ALIAS: VAL_CD
> STANDARD ALIAS: CLM_VAL_CD
> SYSTEM ALIAS: LTVALUE
> TITLE ALIAS: VALUE_CD
>
> CODES:
> REFER TO: CLM_VAL_TB
> IN THE CODES APPENDIX
>
> SOURCE:
> CWF

VALAMT{x}
where { x } ranges from 1 to 36

Claim Value Amount

> The amount related to the condition identified in the
> CLM_VAL_CD which was used by the intermediary
> to process the institutional
> claim.
>
> 9.2 DIGITS SIGNED
>
> DB2 ALIAS: CLM_VAL_AMT
> SAS ALIAS: VALAMT{x}
> STANDARD ALIAS: CLM_VAL_AMT
> TITLE ALIAS: VALUE_AMOUNT
>
> EDIT-RULES:
> +9(9).99
>
> SOURCE:
> CWF

RVCNTR{x}
where { x } ranges from 1 to 45

Revenue Center Code

> If there are more than 45 revenue center trailer elements from
> the source file, then there is one segment for each set of 45
> revenue center trailer elements, up to a maximum of 10 segments
> (total maximum = 450 revenue center trailer elements).
>
> The provider-assigned revenue code for each cost center
> for which a separate charge is billed (type of
> ancillary). A cost center is a division or unit within a
> hospital (e.g., radiology, emergency room, pathology).
> EXCEPTION: Revenue center code 0001 represents the
> total of
> all revenue centers included on the
> claim. COBOL ALIAS: REV_CD
> DB2 ALIAS: REV_CNTR_CD
> SAS ALIAS: RVCNTR{x}
> STANDARD ALIAS: REV_CNTR_CD
> SYSTEM ALIAS: LTRC
> TITLE ALIAS: REVENUE_CENTER_CD
>
> CODES:
> REFER TO: REV_CNTR_TB
> IN THE CODES APPENDIX
> SOURCE: CWF

Variable Name	Label
REV_DT{x}	*Revenue Center Date*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

For the ENCRYPTED Standard View of the Hospice files, the date applicable to the service represented by the revenue center code is coded as the service represented by the revenue center code occurred.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date re-presents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

8 DIGITS UNSIGNED

DB2 ALIAS: REV_CNTR_DT
SAS ALIAS: REV_DT{x}
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCYY
REPRESENTS THE YEAR.

SOURCE:
CWF

Variable Name	Label

APCPPS{x}   *Revenue Center APC/HIPPS Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS.

Effective with Home Health PPS (HHPPS), this field will only be populated with a HIPPS code if the HIPPS code that is stored in the HCPCS field has been downcoded and the new code will be placed in this field.

NOTE1: Under SNF PPS and HHPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded the downcoded HIPPS will be stored in this field.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_APC_HIPPS_CD
SAS ALIAS: APCPPS{x}
STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
SYSTEM ALIAS: LTAPC
TITLE ALIAS: APC_HIPPS

CODES:
REFER TO: REV_CNTR_APC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

HCPSCD{x}   *Revenue Center HCFA Common Procedure Coding*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements). HCFA's Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2 ALIAS: REV_CNTR_HCPCS_CD
SAS ALIAS: HCPSCD{x}
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD
CODES:
REFER TO: CLM_HIPPS_TB
IN THE CODES APPENDIX

Variable Name	*Label*

COMMENT:
Prior to Version H this field was named:
HCPCS_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS)
or '0023' (HH PPS), this field contains the Health
Insurance PPS (HIPPS) code. The HIPPS code for
SNF PPS contains the rate code/assessment type that
identifies (1) RUG-III group the beneficiary was
classified into as of the RAI MDS assessment
reference date and (2) the type of assessment for
payment pur-poses.
The HIPPS code for Home Health PPS identifies
(1) the three case-mix dimensions of the HHRG
system, clinical, functional and utilization, from which a
beneficiary is assigned to one of the 80 HHRG
categories and (2) it identifies whether or not
the elements of the code were computed or derived.
The HHRGs, represented by the HIPPS coding, will
be the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see
CLM_HIPPS_TB.

Level I
Codes and descriptors copyrighted by the American
Medical Association's Current Procedural
Terminology, Fourth Edition (CPT-4). These are
5 position numeric codes representing physician
and nonphysician services.

**** Note: ****
CPT-4 codes including both long and short
descriptions shall be used in accordance with the
HCFA/AMA agreement. Any other use violates the
AMA copyright.

Level II
Includes codes and descriptors copyrighted by
the American Dental Association's Current Dental
Terminology, Second Edition (CDT-2). These are
5 position alpha-numeric codes comprising
the D series. All other level II codes and
descriptors are approved and maintained jointly by
the alpha-numeric editorial panel (consisting of
HCFA, the Health Insurance Association of
America, and the Blue Cross and Blue Shield
Association). These are 5 position alpha-
numeric codes representing primarily items
and nonphysician services that are not
represented in the level I codes.

Level III
Codes and descriptors developed by Medicare
carriers for use at the local (carrier) level. These
are 5 position alpha-numeric codes in the W, X,
Y or Z series representing physician
and nonphysician services that are not
represented in the level I or level II codes.

Variable Name	*Label*

MDCD1_{x}   *Revenue Center HCPCS Initial Modifier Code*
where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).

A first modifier to the procedure code to enable a
more specific procedure identification for the claim.
DB2 ALIAS: REV_HCPCS_MDFR_CD
SAS ALIAS: MDCD1_{x}
STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD
TITLE ALIAS: INITIAL_MODIFIER

EDIT-RULES:
Carrier Information File

COMMENT:
Prior to Version H this field was named:
HCPCS_INITL_MDFR_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
non-institutional: LINE).

SOURCE:
CWF

MDCD2_{x}   *Revenue Center HCPCS Second Modifier Code*
where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).

A second modifier to the procedure code to make it
more specific than the first modifier code to identify the
procedures performed on the beneficiary for the claim.
DB2 ALIAS: REV_HCPCS_2ND_CD
SAS ALIAS: MDCD2_{x}
STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD
TITLE ALIAS: SECOND_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
Prior to Version H this field was named:
HCPCS_2ND_MDFR_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
non-institutional: LINE).

SOURCE:
CWF

Variable Name	Label

MDCD3_{x}   *Revenue Center HCPCS Third Modifier Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_3RD_CD
SAS ALIAS: MDCD3_{x}
STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS: THIRD_MODIFIER

EDIT-RULES:
CARRIER INFORMATION
FILE COMMENT:
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE:
CWF

MDCD4_{x}   *Revenue Center HCPCS Fourth Modifier Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_4TH_CD
SAS ALIAS: MDCD4_{x}
STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE ALIAS: FOURTH_MODIFIER
EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE:
CWF

MDCD5_{x}   *Revenue Center HCPCS Fifth Modifier Code*

where { x } ranges from 1 to 45

> If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).
>
> Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim.
>
> DB2 ALIAS: REV_HCPCS_5TH_CD
> SAS ALIAS: MDCD5_{x}
> STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD
> TITLE ALIAS: FIFTH_MODIFIER
>
> EDIT-RULES:
> CARRIER INFORMATION FILE
>
> COMMENT:
> NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.
>
> SOURCE:
> CWF

PMTTHD{x}   *Revenue Center Payment Method Indicator Code*

where { x } ranges from 1 to 45

> If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).
>
> Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data,
> 1st position being the service indicator and the
> 2nd position being the payment indicator.
>
> NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.
>
> DB2 ALIAS: REV_PMT_MTHD_CD
> SAS ALIAS: PMTTHD{x}
> STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
> SYSTEM ALIAS: LTPMTHD
> TITLE ALIAS: PMT_MTHD
>
> CODES:
> REFER TO: REV_CNTR_PMT_MTHD_IND_TB
> IN THE CODES APPENDIX
> SOURCE:
> CWF

Variable Name	Label

DSCTND{x}
where { x } ranges from 1 to 45

Revenue Center Discount Indicator Code

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. **If there is no discounting the factor will be 1.0.**

NOTE1: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_DSCNT_IND_CD
SAS ALIAS: DSCTND{x}
STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
SYSTEM ALIAS: LTDSCNT
TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

CODES:
DISCOUNTING FORMULAS
$1 = 1.0$
$2 = (1.0+D(U-1))/U$
$3 = T/U$
$4 = (1+D)/U$
$5 = D$
$6 = TD/U$
$7 = D(1+D)/U$
$8 = 2.0/U$

SOURCE:
CWF

PCKGND{x}
where { x } ranges from 1 to 45

Revenue Center Packaging Indicator Code

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', for all services subject to Outpatient PPS, the code used to identify those services that are packaged/bundled with another service.

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_PACKG_IND_CD
SAS ALIAS: PCKGND{x}
STANDARD ALIAS: REV_CNTR_PACKG_IND_CD
SYSTEM ALIAS: LTPACKG
TITLE ALIAS: REV_CNTR_PACKG_IND

Variable Name	Label

CODES:
0 = Not packaged
1 = Packaged service (service indicator N)
2 = Packaged as part of partial hospitalization
per diem or daily mental health service
per diem

SOURCE:
CWF

PRICNG{x}　　　　　　　　　　*Revenue Center Pricing Indicator Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the code used to identify if there
was a deviation from the standard method of calculating
payment amount.

NOTE: Beginning with NCH weekly process date
8/18/00, this field will be populated with data.
Claims processed prior to 8/18/00 will contain
spaces in this field.

DB2 ALIAS: REV_PRICNG_IND_CD
SAS ALIAS: PRICNG
STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD
SYSTEM ALIAS: LTPRICNG
TITLE ALIAS: REV_CNTR_PRICNG_IND

CODES:
REFER TO: REV_CNTR_PRICNG_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

OTAF1_{x}　　　　　　　　　　*Revenue Center Obligation to Accept As Full (OTAF)*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).
Effective with Version 'I' the code used to indicate that
the provider was obligated to accept as full payment the
amount received from the primary (or secondary) payer.

NOTE: Beginning with NCH weekly process date
7/7/00, this field will be populated with data.
Claims processed prior to 7/7/00 will contain
spaces in this field.

DB2 ALIAS: REV_OTAF1_IND_CD
SAS ALIAS: OTAF1_{x}
STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD
TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD

EDIT-RULES:
Y = provider is obligated to accept the payment
as payment in full for the service.
N or blank = provider is not obligated to accept
the payment, or there is no payment by a prior
payer.

SOURCE: CWF

Variable Name	Label
IDENDC{x}	*Revenue Center IDE, NDC, UPC Number*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H con-version IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly pro-cess dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS: IDE_NDC_UPC_NUM
SAS ALIAS: IDENDC
STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
TITLE ALIAS: IDE_NDC_UPC

SOURCE:
CWF

Variable Name	Label

RVUNT{x}   *Revenue Center Unit Count*

where { x } ranges from 1 to 45

> If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).
>
> A quantitative measure (unit) of the number of times the service or procedure being reported was performed to the revenue center/HCPCS code definition as an institutional claim.
>
> Depending on type of service, units are measured by of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.
>
> NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each code and, if applicable, the number of visits for each rehab therapy code.
>
> 7 DIGITS SIGNED
>
> DB2 ALIAS: REV_CNTR_UNIT_CNT
> SAS ALIAS: RVUNT{x}
> STANDARD ALIAS: REV_CNTR_UNIT_CNT
> TITLE ALIAS: UNITS
>
> EDIT- RULES:
> +9(7)
>
> SOURCE:
> CWF

RVRT{x}   *Revenue Center Rate Amount*

where { x } ranges from 1 to 45

> If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).
>
> Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.
>
> NOTE1: For SNF PPS claims (when revenue center code equals '0022'), HCFA has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).
>
> NOTE2: For OP PPS claims, HCFA has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.
>
> NOTE3: Under HH PPS (when revenue center code equals '0023'), HCFA has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index

Variable Name	*Label*

for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_RATE_AMT
SAS ALIAS: RVRT{x}
STANDARD ALIAS: REV_CNTR_RATE_AMT
TITLE ALIAS: CHARGE_PER_UNIT

EDIT-RULES:
+9(9).99

EFFECTIVE-DATE: 10/01/1993

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

RVBLD{x} *Revenue Center Blood Deductible Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_BLOOD_DDCTBL
SAS ALIAS: RVBLD{x}
STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT
TITLE ALIAS: BLOOD_DDCTBL_AMT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

Variable Name	Label

RVDTBL{x}   *Revenue Center Cash Deductible Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED
DB2 ALIAS: REV_CASH_DDCTBL
SAS ALIAS: RVDTBL{x}
STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT
TITLE ALIAS: CASH_DDCTBL

EDIT-RULES:
+9(9).99

SOURCE:
CWF

WGDJ{x}   *Revenue Center Coinsurance/Wage Adjusted*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.
9.2 DIGITS SIGNED

DB2 ALIAS: ADJSTD_COINSRNC
SAS ALIAS: WGDJ{x}
STANDARD ALIAS:
REV_CNTR_WAGE_ADJSTD_COINS_AMT
TITLE ALIAS: WAGE_ADJSTD_COINS

Variable Name	Label

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RDCDCN{x}

Revenue Center Reduced Coinsurance Amount

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: RDCD_COINSRNC
SAS ALIAS: RDCDCN{x}
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS: REDUCED_COINS

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVMS1_{x}

Revenue Center 1st Medicare Secondary Payer Paid

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP1_PD_AMT
SAS ALIAS: RVMS1_{x}
STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:
+9(9).99
SOURCE: CWF

Variable Name	Label

RVMS2_{x}   **Revenue Center 2nd Medicare Secondary Payer Paid**

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.
9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP2_PD_AMT
SAS ALIAS: RVMS2_{x}
STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT

TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RPRPMT{x}   **Revenue Center Provider Payment Amount**

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_PRVDR_PMT_AMT
SAS ALIAS: RPRPMT{x}
STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
TITLE ALIAS: REV_PRVDR_PMT

EDIT-RULES:
+9(9).99
SOURCE:
CWF

Variable Name	Label

RBNPMT{x}   *Revenue Center Beneficiary Payment Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).

Effective with Version I, the amount paid to the beneficiary
for the services reported on the line item.

NOTE: Beginning with NCH weekly process date
7/7/00, this field will be populated with data.
Claims processed prior to 7/7/00 will contain
spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_BENE_PMT_AMT
SAS ALIAS: RBNPMT{x}
STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
TITLE ALIAS: REV_BENE_PMT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

PTNRSP{x}   *Revenue Center Patient Responsibility Payment Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).
Effective with Version I, the amount paid by the
beneficiary to the provider for the line item service.

NOTE: Beginning with NCH weekly process date
7/7/00 this field was populated with data.
Claims processed prior to 7/7/00 will
contain zeroes in this field.
9.2 DIGITS SIGNED

DB2 ALIAS: REV_PTNT_RESP_AMT
SAS ALIAS: PTNRSP{x}
STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS: REV_PTNT_RESP

EDIT-RULES:
+9(9).99

SOURCE:
CWF

Variable Name	Label

REVPMT{x}   *Revenue Center Payment Amount*

where { x } ranges from 1 to 45

> If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).
>
> Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.
>
> Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC.
>
> Under HH PPS, PRICER will compute/return a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field.
>
> 9.2 DIGITS SIGNED
>
> COMMON ALIAS: REIMBURSEMENT
> DB2 ALIAS: REV_CNTR_PMT_AMT
> SAS ALIAS: REVPMT
> STANDARD ALIAS: REV_CNTR_PMT_AMT
> TITLE ALIAS: REIMBURSEMENT
>
> EDIT-RULES:
> +9(9).99
> SOURCE:
> CWF

RVCHRG{x}   *Revenue Center Total Charge Amount*

where { x } ranges from 1 to 45

> If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).
>
> The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).
>
> EXCEPTIONS:
> (1) For SNF RUGS demo claims only (9000 series center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have applicable if the provider had not been participating in the demo).
>
> (2) For SNF PPS (non demo claims), when revenue center code
> = '0022', the total charges will be zero.
>
> (3) For Home Health PPS (RAPs), when revenue center code =
> '0023', the total charges will equal the dollar amount for the '0023' line.

Variable Name	Label

(4) For Home Health PPS (final claim), when revenue code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the charges will be $1 (rate) times units (days).

9.2 DIGITS SIGNED

DB2 ALIAS: REV_TOT_CHRG_AMT
SAS ALIAS: RVCHRG{x}
STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS: REVENUE_CENTER_CHARGES

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

RVNCVR{x}   *Revenue Center Non-Covered Charge Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

The charge amount related to a revenue center code for services that are not covered by Medicare.
NOTE: Prior to Version H the field size was S9(7)V99
the element was only present on the Inpatient/SNF
As of NCH weekly process date 10/3/97 this field was
to all institutional claim types.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_NCVR_CHRG_AMT
SAS ALIAS: RVNCVR{x}
STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT
TITLE ALIAS:

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVDDCD{x}   *Revenue Center Deductible Coinsurance Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from
the source file, then there is one segment for each set of 45
revenue center trailer elements, up to a maximum of 10 segments
(total maximum = 450 revenue center trailer elements).

Code indicating whether the revenue center charges
are subject to deductible and/or coinsurance.
DB2 ALIAS: DDCTBL_COINSRNC_CD
SAS ALIAS: RVDDCD{x}
STANDARD ALIAS:
TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

CODES:
REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF