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
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

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 the quarter of the calendar year 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:
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

SOURCE:
CWF

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

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*

This field is no longer populated as it is unavailable from the data source.

TRANS_CD — *Claim Transaction Code*

This field is no longer populated as it is unavailable from the data source.

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

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

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

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

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

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

This field is no longer populated as it is unavailable from the data source.

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 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'

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*

This field is no longer populated as it is unavailable from the data source.

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

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

OP_UPIN — *Claim Operating Physician UPIN Number*

This field is no longer populated as it is unavailable from the data source.

OT_UPIN — *Claim Other Physician UPIN Number*

This field is no longer populated as it is unavailable from the data source.

MCOPDSWT — *Claim MCO Paid Switch*

This field is no longer populated as it is unavailable from the data source.

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*

This field is no longer populated as it is unavailable from the data source.

PPS_IND — *Claim PPS Indicator Code*

This field is no longer populated as it is unavailable from the data source.

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

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

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

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

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 quarter of the calendar year 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:
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

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

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

AT_NPI — *Claim Attending Physician NPI Number*

On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the

NCH for those physicians.

SAS ALIAS: AT_NPI
STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM

ORGNPINM — *Organization NPI Number*

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

SAS ALIAS: ORGNPINM
STANDARD ALIAS: ORG_NPI_NUM

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*

This field is no longer populated as it is unavailable from the data source.

PRCDRDT{x} — *Claim Procedure Performed Date*

This field is no longer populated as it is unavailable from the data source.

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

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 the quarter of the calendar year 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:
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
SOURCE:
CWF

VAL_CD{x} — *Claim Value Code*

where { x } ranges from 1 to 36

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} — *Claim Value Amount*

where { x } ranges from 1 to 36

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} *Revenue Center 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).

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

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 quarter of the calendar year when 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 represents 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:
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

SOURCE:
CWF

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

This field is no longer populated as it is unavailable from the data source.

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

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.

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

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

This field is no longer populated as it is unavailable from the data source.

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

This field is no longer populated as it is unavailable from the data source.

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

This field is no longer populated as it is unavailable from the data source.

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

This field is no longer populated as it is unavailable from the data source.

DSCTND{x} — *Revenue Center Discount Indicator Code*

This field is no longer populated as it is unavailable from the data source.

PCKGND{x} — *Revenue Center Packaging Indicator Code*

This field is no longer populated as it is unavailable from the data source.

PRICNG{x} — *Revenue Center Pricing Indicator Code*

This field is no longer populated as it is unavailable from the data source.

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

This field is no longer populated as it is unavailable from the data source.

IDENDC{x} — *Revenue Center IDE, NDC, UPC Number*

This field is no longer populated as it is unavailable from the data source.

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 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*

This field is no longer populated as it is unavailable from the data source.

RVDTBL{x} — *Revenue Center Cash Deductible Amount*

This field is no longer populated as it is unavailable from the data source.

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

This field is no longer populated as it is unavailable from the data source.

RDCDCN{x} — *Revenue Center Reduced Coinsurance Amount*

This field is no longer populated as it is unavailable from the data source.

RVMS1_{x} — *Revenue Center 1st Medicare Secondary Payer Paid*

This field is no longer populated as it is unavailable from the data source.

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

This field is no longer populated as it is unavailable from the data source.

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

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*

This field is no longer populated as it is unavailable from the data source.

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.

(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