Research Data Distribution Center
Home Health Claim Record -- Data Dictionary For SAS and CSV Datasets

Variable Name	Label
BID	Beneficiary Identification Number

Beneficiary Identification Number for this data request

REC_LEN	Record Length Count

Effective with Version H, the count (in bytes) of the length of the claim record.
NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).
5 DIGITS SIGNED
DB2 ALIAS: REC_LNGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LNGTH_CNT
SOURCE:
NCH

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
COMMENT:
Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD.
SOURCE:
NCH

RIC_CD	NCH Near Line Record Identification Code

A code defining the type of claim record being processed.
COMMON ALIAS: RIC
DB2 ALIAS: NEAR_LINE_RIC_CD
SAS ALIAS: RIC_CD
STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD
TITLE ALIAS: RIC
CODES:
REFER TO: NCH_NEAR_LINE_RIC_TB

Variable Name	Label
	IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: RIC_CD. SOURCE: NCH
MQA_RIC	*NCH MQA RIC Code*
	Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through HCFA's CWFMQA system. NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_MQA_RIC_CD SAS ALIAS: MQA_RIC STANDARD ALIAS: NCH_MQA_RIC_CD TITLE ALIAS: MQA_RIC CODES: 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency 6 = Physician/Supplier 7 = Durable Medical Equipment SOURCE: NCH QA PROCESS
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: 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

Variable Name	*Label*
	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 CODE 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'

Variable Name	*Label*
	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

Variable Name	Label
	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 DMERC 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
CAN	*Beneficiary Claim Account Number (BLANKED)*
	The number identifying the primary beneficiary under the SSA or RRB programs submitted. COMMON ALIAS: CAN DA3 ALIAS: CLAIM_ACCOUNT_NUMBER DB2 ALIAS: BENE_CLM_ACNT_NUM SAS ALIAS: CAN STANDARD ALIAS: BENE_CLM_ACNT_NUM TITLE ALIAS: CAN SOURCE: SSA,RRB LIMITATIONS: RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.
EQ_BIC	*NCH Category Equatable Beneficiary Identification Code*
	The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner. The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.) COMMON ALIAS: NCH_BASE_CATEGORY_BIC DB2 ALIAS: CTGRY_EQTBL_BIC SAS ALIAS: EQ_BIC

Variable Name	Label
	STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD TITLE ALIAS: EQUATED_BIC CODES: REFER TO: CTGRY_EQTBL_BENE_IDENT_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CTGRY_EQTBL_BENE_IDENT_CD. SOURCE: BIC EQUATE MODULE
BIC	*Beneficiary Identification Code*
	The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary. COMMON ALIAS: BIC DA3 ALIAS: BENE_IDENT_CODE DB2 ALIAS: BENE_IDENT_CD SAS ALIAS: BIC STANDARD ALIAS: BENE_IDENT_CD TITLE ALIAS: BIC EDIT-RULES: EDB REQUIRED FIELD CODES: REFER TO: BENE_IDENT_TB IN THE CODES APPENDIX SOURCE: SSA/RRB
ST_SGMT	*NCH State Segment Code*
	The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.) DB2 ALIAS: NCH_STATE_SGMT_CD SAS ALIAS: ST_SGMT STANDARD ALIAS: NCH_STATE_SGMT_CD TITLE ALIAS: NEAR_LINE_SEGMENT CODES: REFER TO: NCH_STATE_SGMT_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: BENE_STATE_SGMT_NEAR_LINE_CD. 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:

Variable Name	Label
	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
FROM_DT	*Claim From Date*
	The first day on the billing statement covering services rendered to the bene- ficiary (a.k.a. 'Statement Covers From Date'). 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_FROM_DT SAS ALIAS: FROM_DT STANDARD ALIAS: CLM_FROM_DT TITLE ALIAS: FROM_DATE EDIT-RULES: YYYYMMDD SOURCE: CWF
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'). 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: YYYYMMDD SOURCE: CWF
WKLY_DT	*NCH Weekly Claim Processing Date*
	The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date. 8 DIGITS UNSIGNED

Variable Name	Label
	DB2 ALIAS: NCH_WKLY_PROC_DT SAS ALIAS: WKLY_DT STANDARD ALIAS: NCH_WKLY_PROC_DT TITLE ALIAS: NCH_PROCESS_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: HCFA_CLM_PROC_DT. SOURCE: NCH
ACRTN_DT	*CWF Claim Accretion Date*
	The date the claim record is accreted (posted/ processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal interme- diary or carrier. 8 DIGITS UNSIGNED DB2 ALIAS: CWF_CLM_ACRTN_DT SAS ALIAS: ACRTN_DT STANDARD ALIAS: CWF_CLM_ACRTN_DT TITLE ALIAS: ACCRETION_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
ACRTN_NM	*CWF Claim Accretion Number*
	The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. **(Exception: If the claim record is missing the accretion date HCFA's CWFMQA system places a zero in the accretion number. 3 DIGITS SIGNED DB2 ALIAS: CWF_CLM_ACRTN_NUM SAS ALIAS: ACRTN_NM STANDARD ALIAS: CWF_CLM_ACRTN_NUM TITLE ALIAS: ACCRETION_NUMBER SOURCE: CWF
CLM_CNTL	*FI Document Claim Control Number*
	Unique control number assigned by an intermediary to an institutional claim. COMMON ALIAS: ICN DB2 ALIAS: DOC_CLM_CNTL_NUM SAS ALIAS: CLM_CNTL STANDARD ALIAS: FI_DOC_CLM_CNTL_NUM TITLE ALIAS: ICN SOURCE: CWF
ORIGCNTL	*FI Original Claim Control Number*

Variable Name	*Label*
	Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted. COMMON ALIAS: ORIGINAL_ICN DB2 ALIAS: ORIG_CLM_CNTL_NUM SAS ALIAS: ORIGCNTL STANDARD ALIAS: FI_ORIG_CLM_CNTL_NUM TITLE ALIAS: ORIGINAL_ICN 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
DAILY_DT	*NCH Daily Process Date*
	Effective with Version H, the date the claim record was processed by HCFA's CWFMQA system (used for internal editing purposes). Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/ segments together. NOTE1: With Version 'H' this field was pop- ulated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date. 8 DIGITS UNSIGNED

Variable Name	Label
	DB2 ALIAS: NCH_DAILY_PROC_DT SAS ALIAS: DAILY_DT STANDARD ALIAS: NCH_DAILY_PROC_DT TITLE ALIAS: DAILY_PROCESS_DT EDIT-RULES: YYYYMMDD SOURCE: NCH
LINK_NUM	*NCH Segment Link Number*
	Effective with Version 'I', the system gen- erated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/ segments that come in on the same batch with the same identifying information in the link group are not mixed with each other. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). 9 DIGITS SIGNED DB2 ALIAS: NCH_SGMT_LINK_NUM SAS ALIAS: LINK_NUM STANDARD ALIAS: NCH_SGMT_LINK_NUM TITLE ALIAS: LINK_NUM SOURCE: NCH
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. NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1. 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).

Variable Name	Label
	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
LINECNT	*Claim Total Line Count*
	Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450. 3 DIGITS UNSIGNED DB2 ALIAS: TOT_LINE_CNT SAS ALIAS: LINECNT STANDARD ALIAS: CLM_TOT_LINE_CNT TITLE ALIAS: TOTAL_LINE_COUNT SOURCE: CWF
SGMTLINE	*Claim Segment Line Count*
	Effective with Version I, the count used to identify the number of revenue center lines on a record/segment. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment is 45. 2 DIGITS UNSIGNED DB2 ALIAS: SGMT_LINE_CNT SAS ALIAS: SGMTLINE STANDARD ALIAS: CLM_SGMT_LINE_CNT TITLE ALIAS: SEGMENT_LINE_COUNT 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.

Variable Name	Label
	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
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

Variable Name	Label
	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
MQAQUERY	*NCH MQA Query Patch Code*
	Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record. NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MQA_QUERY_PATCH_CD SAS ALIAS: MQAQUERY STANDARD ALIAS: NCH_MQA_QUERY_PATCH_CD TITLE ALIAS: MQA_QUERY_PATCH_IND CODES: Y = MQA changed bill query code on a action code 6 (force action code 2) bill to a zero. (Eff. 10/12/93) Z = MQA changed bill query code on a action code 4 (cancel only adjustment) bill to zero. (Eff. 5/16/94) SOURCE: NCH QA Process
DISP_CD	*Claim Disposition Code*
	Code indicating the disposition or outcome of the processingof the claim record. DB2 ALIAS: CLM_DISP_CD SAS ALIAS: DISP_CD STANDARD ALIAS: CLM_DISP_CD TITLE ALIAS: DISPOSITION_CD CODES: REFER TO: CLM_DISP_TB IN THE CODES APPENDIX SOURCE: CWF
EDITDISP	*NCH Edit Disposition Code*
	Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process. NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_EDIT_DISP_CD SAS ALIAS: EDITDISP STANDARD ALIAS: NCH_EDIT_DISP_CD TITLE ALIAS: NCH_EDIT_DISP

Variable Name	Label
	CODES: 00 = No MQA errors 10 = Possible duplicate 20 = Utilization error 30 = Consistency error 40 = Entitlement error 50 = Identification error 60 = Logical duplicate 70 = Systems duplicate SOURCE: NCH QA Process
BIC_MDFY	*NCH Claim BIC Modify H Code*
	Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC. NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_BIC_MDFY_CD SAS ALIAS: BIC_MDFY STANDARD ALIAS: NCH_CLM_BIC_MDFY_CD TITLE ALIAS: BIC_MODIFY_CD CODES: H = BIC submitted by CWF = HA, HB or HC blank = No HA, HB or HC BIC present SOURCE: NCH QA Process
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: BENE_RSDNC_SSA_STD_CNTY_CD TITLE ALIAS: BENE_COUNTY_CD EDIT-RULES: OPTIONAL: MAY BE BLANK SOURCE: SSA/EDB
RCPT_DT	*FI Claim Receipt Date*
	The date the fiscal intermediary received the institutional claim from the provider. 8 DIGITS UNSIGNED DB2 ALIAS: FI_CLM_RCPT_DT SAS ALIAS: RCPT_DT STANDARD ALIAS: FI_CLM_RCPT_DT TITLE ALIAS: RECEIPT_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: FICARR_CLM_RCPT_DT. SOURCE: CWF
SCHLD_DT	*FI Claim Scheduled Payment Date*

Variable Name	*Label*
	The scheduled date of payment to the institu- tional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available. 8 DIGITS UNSIGNED DB2 ALIAS: FI_SCHLD_PMT_DT SAS ALIAS: SCHLD_DT STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT TITLE ALIAS: SCHEDULED_PMT_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: FICARR_CLM_PMT_DT. SOURCE: CWF
FRWRD_DT	*CWF Forwarded Date*
	Effective with Version H, the date CWF forwarded the claim record to HCFA (used for internal editing purposes). NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 8 DIGITS UNSIGNED DB2 ALIAS: CWF_FRWRD_DT SAS ALIAS: FRWRD_DT STANDARD ALIAS: CWF_FRWRD_DT TITLE ALIAS: FORWARD_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
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
ASGN_NUM	*CWF Claim Assigned Number*
	Effective with Version H, the number assigned to an institutional claim record by CWF (used for internal editing purposes). NOTE: Beginning with NCH weekly process date

Variable Name	Label
	10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: CWF_CLM_ASGN_NUM SAS ALIAS: ASGN_NUM STANDARD ALIAS: CWF_CLM_ASGN_NUM TITLE ALIAS: ASSIGNED_NUM SOURCE: CWF
FIBATCH	*CWF Transmission Batch Number*
	Effective with Version H, the number assigned to each batch of claims transactions sent from CWF(used for internal editing purposes). NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field. DB2 ALIAS: TRNSMSN_BATCH_NUM SAS ALIAS: FIBATCH STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM TITLE ALIAS: BATCH_NUM SOURCE: CWF
BENE_ZIP	*Beneficiary Mailing Contact ZIP Code*
	The ZIP code of the mailing address where the beneficiary may be contacted. DB2 ALIAS: BENE_MLG_ZIP_CD SAS ALIAS: BENE_ZIP STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD TITLE ALIAS: BENE_ZIP SOURCE: EDB
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

Variable Name	*Label*
	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. 8 DIGITS UNSIGNED DB2 ALIAS: BENE_BIRTH_DT SAS ALIAS: BENE_DOB STANDARD ALIAS: BENE_BIRTH_DT TITLE ALIAS: BENE_BIRTH_DATE EDIT-RULES: YYYYMMDD 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

Variable Name	Label
	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
SURNAME	*Claim Patient 6 Position Surname*
	The first 6 positions of the Medicare patient's surname (last name) as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field. COMMON ALIAS: PATIENT_SURNAME DB2 ALIAS: PTNT_6_PSTN_SRNM SAS ALIAS: SURNAME STANDARD ALIAS: CLM_PTNT_6_PSTN_SRNM_NAME TITLE ALIAS: PATIENT_SURNAME SOURCE: CWF
FRSTINIT	*Claim Patient 1st Initial Given Name*
	The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field. COMMON ALIAS: PATIENT_GIVEN_NAME DB2 ALIAS: 1ST_INITL_GVN_NAME SAS ALIAS: FRSTINIT STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME TITLE ALIAS: PATIENT_FIRST_INITIAL SOURCE: CWF
MDL_INIT	*Claim Patient First Initial Middle Name*
	The first initial of the Medicare patient's middle name as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH

Variable Name	Label
	weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field. COMMON ALIAS: PATIENT_MIDDLE_NAME DB2 ALIAS: 1ST_INITL_MDL_NAME SAS ALIAS: MDL_INIT STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME TITLE ALIAS: PATIENT_MIDDLE_INITIAL SOURCE: CWF
CWFLOCCD	*Beneficiary CWF Location Code*
	The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained. COMMON ALIAS: CWF_HOST DB2 ALIAS: BENE_CWF_LOC_CD SAS ALIAS: CWFLOCCD STANDARD ALIAS: BENE_CWF_LOC_CD SYSTEM ALIAS: LTCWFLOC TITLE ALIAS: CWF_HOST CODES: B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific 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 to 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.

Variable Name	*Label*
	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/Nonexcepted 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 required 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 present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded 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 a 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 patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 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

Variable Name	Label
	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 code '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 coinsurance 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 into an appropriate case mix category known as the Home Health 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 mix episode payment. The payment is then wage index For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment 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

Variable Name	*Label*
	TITLE ALIAS: REIMBURSEMENT EDIT-RULES: $$$$$$$$$CC COMMENT: Prior to Version H the size of this field was S9(7)V99. Als the noninstitutional claim records carried this field as a l item. Effective with Version H, this element is a claim lev field across all claim types (and the line item field has be renamed.) SOURCE: CWF LIMITATIONS: Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.
PRPAYAMT	*NCH Primary Payer Claim Paid Amount*
	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that theprovider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim. 9.2 DIGITS SIGNED DB2 ALIAS: PRMRY_PYR_PD_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT EDIT-RULES: $$$$$$$$$CC 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

Variable Name	Label
	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*
	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
APRVL_DT	*FI Claim Process Date*

The date the fiscal intermediary completes processing and releases the institutional
claim to the CWF host.
8 DIGITS UNSIGNED
DB2 ALIAS: FI_CLM_PROC_DT
SAS ALIAS: APRVL_DT
STANDARD ALIAS: FI_CLM_PROC_DT
TITLE ALIAS: FI_PROCESS_DT
EDIT-RULES:
YYYYMMDD
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 year 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

ORGNPINM	*Organization NPI Number*

A placeholder field (effective with Version H) for storing the NPI assigned to the institutional provider.
DB2 ALIAS: ORG_NPI_NUM
SAS ALIAS: ORGNPINM
STANDARD ALIAS: ORG_NPI_NUM
TITLE ALIAS: ORG_NPI
SOURCE:
CWF

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

Variable Name	Label
	rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician). 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 contained 10 positions (6-position UPIN and 4-position physician surname). SOURCE: CWF
AT_NPI	*Claim Attending Physician NPI Number*
	A placeholder field (effective with Version H) for storing the NPI assigned to the attending physician. COMMON ALIAS: ATTENDING_PHYSICIAN_NPI DB2 ALIAS: ATNDG_NPI SAS ALIAS: AT_NPI STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM TITLE ALIAS: ATNDG_NPI SOURCE: CWF
AT_SRNM	*Claim Attending Physician Surname*
	Effective with Version H, the last name of the attending physician (used for internal editing purpose in HCFA's CWFMQA system.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: ATNDG_SRNM SAS ALIAS: AT_SRNM STANDARD ALIAS: CLM_ATNDG_PHYSN_SRNM_NAME TITLE ALIAS: ANDG_PHYSN_SURNAME SOURCE: CWF
AT_GVNNM	*Claim Attending Physician Given Name*
	Effective with Version H, the first name of the attending physician (used for internal editing purposes in HCFA's CWFMQA system). NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: ATNDG_GVN_NAME SAS ALIAS: AT_GVNNM STANDARD ALIAS: CLM_ATNDG_PHYSN_GVN_NAME TITLE ALIAS: ATNDG_PHYSN_FIRSTNAME SOURCE: CWF
AT_MDL	*Claim Attending Physician Middle Initial Name*

Variable Name	*Label*
	Effective with Version H, the middle initial of the attending physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: ATNDG_MI_NAME SAS ALIAS: AT_MDL STANDARD ALIAS: CLM_ATNDG_PHYSN_MDL_INITL_NAME TITLE ALIAS: ATNDG_PHYSN_MI SOURCE: CWF
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. 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
OP_NPI	*Claim Operating Physician NPI Number*
	A placeholder field (effective with Version H) for storing the NPI assigned to the operating physician. DB2 ALIAS: OPRTG_NPI SAS ALIAS: OP_NPI STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM TITLE ALIAS: OPRTG_NPI SOURCE: CWF
OP_SRNM	*Claim Operating Physician Surname*
	Effective with Version H, the last name of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OPRTG_SRNM SAS ALIAS: OP_SRNM STANDARD ALIAS: CLM_OPRTG_PHYSN_SRNM_NAME

Variable Name	Label
	TITLE ALIAS: OPRTG_PHYSN_SURNAME SOURCE: CWF
OP_GVN	*Claim Operating Physician Given Name*
	Effective with Version H, the first name of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OPRTG_GVN_NAME SAS ALIAS: OP_GVN STANDARD ALIAS: CLM_OPRTG_PHYSN_GVN_NAME TITLE ALIAS: OPRTG_PHYSN_FIRSTNAME SOURCE: CWF
OP_MDL	*Claim Operating Physician Middle Initial Name*
	Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OPRTG_MI_NAME SAS ALIAS: OP_MDL STANDARD ALIAS: CLM_OPRTG_PHYSN_MDL_INITL_NAME TITLE ALIAS: OPRTG_PHYSN_MI 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. 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
OT_NPI	*Claim Other Physician NPI Number*

Variable Name	Label
	A placeholder field (effective with Version H for storing the NPI assigned to the other physician. DB2 ALIAS: OTHR_NPI SAS ALIAS: OT_NPI STANDARD ALIAS: CLM_OTHR_PHYSN_NPI_NUM SOURCE: CWF
OT_SRNM	*Claim Other Physician Surname*
	Effective with Version H, the last name of the other physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OTHR_SRNM SAS ALIAS: OT_SRNM STANDARD ALIAS: CLM_OTHR_PHYSN_SRNM_NAME TITLE ALIAS: OTH_PHYSN_SURNAME SOURCE: CWF
OT_GVN	*Claim Other Physician Given Name*
	Effective with Version H, the first name of the other physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OTHR_GVN_NAME SAS ALIAS: OT_GVN STANDARD ALIAS: CLM_OTHR_PHYSN_GVN_NAME TITLE ALIAS: OTH_PHYSN_FIRSTNAME SOURCE: CWF
OT_MDL	*Claim Other Physician Middle Initial Name*
	Effective with Version H, the middle initial of the other physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OTHR_MI_NAME SAS ALIAS: OT_MDL STANDARD ALIAS: CLM_OTHR_PHYSN_MDL_INITL_NAME TITLE ALIAS: OTH_PHYSN_MI SOURCE: CWF
MDCD_PRV	*Medicaid Provider Identification Number*
	A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and claims history on individual providers for surveillance and

Variable Name	Label
	utilization review. DB2 ALIAS: MDCD_PRVDR_NUM SAS ALIAS: MDCD_PRV STANDARD ALIAS: MDCD_PRVDR_IDENT_NUM TITLE ALIAS: MEDICAID_PROVIDER COMMENT: Prior to Version H the field size was X(12). SOURCE: CWF
MDCDINFO	*Claim Medicaid Information Code*
	Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid. DB2 ALIAS: CLM_MDCD_INFO_CD SAS ALIAS: MDCDINFO STANDARD ALIAS: CLM_MDCD_INFO_CD TITLE ALIAS: MEDICAID_INFO SOURCE: CWF
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
AUTHRZTN	*Claim Treatment Authorization Number*
	The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization. NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code. COMMON ALIAS: TAN DB2 ALIAS: TRTMT_AUTHRZTN_NUM SAS ALIAS: AUTHRZTN STANDARD ALIAS: CLM_TRTMT_AUTHRZTN_NUM

Variable Name	Label
	TITLE ALIAS: TREATMENT_AUTHORIZATION SOURCE: CWF
PTNTCNTL	*Patient Control Number*
	The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payments. DB2 ALIAS: PTNT_CNTL_NUM SAS ALIAS: PTNTCNTL STANDARD ALIAS: PTNT_CNTL_NUM TITLE ALIAS: PATIENT_CONTROL_NUM SOURCE: CWF
MDCL_REC	*Claim Medical Record Number*
	The number assigned by the provider to the beneficiary's medical record to assist in record retrieval. DB2 ALIAS: CLM_MDCL_REC_NUM SAS ALIAS: MDCL_REC STANDARD ALIAS: CLM_MDCL_REC_NUM TITLE ALIAS: MEDICAL_RECORD_NUM SOURCE: CWF
PRO_CNTL	*Claim PRO Control Number*
	Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes. DB2 ALIAS: CLM_PRO_CNTL_NUM SAS ALIAS: PRO_CNTL STANDARD ALIAS: CLM_PRO_CNTL_NUM TITLE ALIAS: PRO_CONTROL_NUM SOURCE: CWF
PRO_DT	*Claim PRO Process Date*
	Effective with Version H, the date the claim was used in the PRO review process. NOTE: 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. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_PRO_PROC_DT SAS ALIAS: PRO_DT STANDARD ALIAS: CLM_PRO_PROC_DT TITLE ALIAS: PRO_PROC_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
STUS_CD	*Patient Discharge Status Code*
	The code used to identify the status of the patient as of the CLM_THRU_DT.

Variable Name	Label
	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
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 populated 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.

Variable Name	Label
	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 COMMENT: Prior to Version H the size of this field was S9(7)V99. SOURCE: CWF
HHEDCNT	*HHA NCH Edit Code Count*
	The count of the number of edit codes annotated to the HHA claim during the HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_EDIT_CD_CNT SAS ALIAS: HHEDCNT STANDARD ALIAS: HHA_NCH_EDIT_CD_CNT COMMENT: Prior to Version H this field was named: CLM_EDIT_CD_CNT. SOURCE: NCH
HHPATCNT	*HHA NCH Patch Code Count*
	Effective with Version H, the count of the number of HCFA patch codes annotated to the home health claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present. NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991). NOTE2: Effective with Version 'I' the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_PATCH_CD_CNT SAS ALIAS: HHPATCNT STANDARD ALIAS: HHA_NCH_PATCH_CD_I_CNT SOURCE: NCH
HHMCOCNT	*HHA MCO Period Count*
	Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an home health agency claim. The purpose of this count is to indicate how many MCO period trailers are present. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.

Variable Name	Label
	Claims processed prior to 10/3/97 will contain zeroes in this field. 1 DIGIT UNSIGNED DB2 ALIAS: HHA_MCO_PRD_CNT SAS ALIAS: HHMCOCNT STANDARD ALIAS: HHA_MCO_PRD_CNT EDIT-RULES: RANGE: 0 TO 2 SOURCE: NCH
HHPLANNT	*HHA Claim Health PlanID Count*
	A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the HHA claim. The purpose of this count is to indicate how many Health PlanID trailers are present. NOTE: Prior to Version 'I' this field was named: HHA_CLM_PAYERID_CNT. 1 DIGIT UNSIGNED DB2 ALIAS: HHA_PLANID_CNT SAS ALIAS: HHPLANNT STANDARD ALIAS: HHA_CLM_HLTH_PLANID_CNT EDIT-RULES: RANGE: 0 TO 3 SOURCE: NCH
HHDEMCNT	*HHA Claim Demonstration ID Count*
	Effective with Version H, the count of the number of claim demonstration IDs reported on an HHA claim. The purpose of this count is to indicate how many claim demonstration trailers are present. NOTE: During the Version H conversion this field was populated with data where a demo was identifiable. 1 DIGIT UNSIGNED DB2 ALIAS: HHA_DEMO_ID_CNT SAS ALIAS: HHDEMCNT STANDARD ALIAS: HHA_CLM_DEMO_ID_CNT EDIT-RULES: RANGE: 0 TO 5 SOURCE: NCH
HHDGNCNT	*HHA Claim Diagnosis Code Count*
	The count of the number of diagnosis codes (both principal and other) reported on an HHA claim. The purpose of this count is to indicate how many claim diagnosis trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_DGNS_CD_CNT SAS ALIAS: HHDGNCNT STANDARD ALIAS: HHA_CLM_DGNS_CD_CNT EDIT-RULES: RANGE: 0 TO 10 COMMENT:

Variable Name	Label
	Prior to Version H this field was named: CLM_OTHR_DGNS_CD_CNT and the principal was not included in the count. SOURCE: NCH
HHCONCNT	*HHA Claim Related Condition Code Count*
	The count of the number of condition codes reported on an HHA claim. The purpose of this count is to indicate how condition code trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_COND_CD_CNT SAS ALIAS: HHCONCNT STANDARD ALIAS: HHA_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
HHOCRCNT	*HHA Claim Related Occurrence Code Count*
	The count of the number of occurrence codes reported on an HHA claim. The purpose of this count is to indicate how many occurrence code trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_RLT_OCRNC_CNT SAS ALIAS: HHOCRCNT STANDARD ALIAS: HHA_CLM_RLT_OCRNC_CD_CNT EDIT-RULES: RANGE: 0 TO 30 COMMENT: Prior to Version H this field was named: CLM_RLT_OCRNC_CD_CNT. SOURCE: NCH
HHSPNCNT	*HHA Claim Occurrence Span Code Count*
	The count of the number of occurrence span codes reported on an HHA claim. The purpose of the count is to indicate how many span code trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_OCRNC_SPAN_CNT SAS ALIAS: HHSPNCNT STANDARD ALIAS: HHA_CLM_OCRNC_SPAN_CD_CNT COMMENT: Prior to Version H this field was named: CLM_OCRNC_SPAN_CD_CNT. SOURCE: NCH
HHVALCNT	*HHA Claim Value Code Count*
	The count of the number of value codes reported on an HHA claim. The purpose of the count is to indicate how many value code trailers are

Variable Name	Label
	present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_CLM_VAL_CD_CNT SAS ALIAS: HHVALCNT STANDARD ALIAS: HHA_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
HHREVCNT	*HHA Revenue Center Code Count*
	The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate how many revenue center trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_REV_CNTR_CNT SAS ALIAS: HHREVCNT STANDARD ALIAS: HHA_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. NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58. SOURCE: NCH
LUPAIND	*Claim HHA Low Utilization Payment Adjustment (LUPA)*
	Effective with Version I, the code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of HHRGs. NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces. DB2 ALIAS: HHA_LUPA_IND_CD SAS ALIAS: LUPAIND STANDARD ALIAS: CLM_HHA_LUPA_IND_CD TITLE ALIAS: HHA_TOT_VISITS CODES: L = LUPA Claim blank = Not a LUPA claim SOURCE: CWF
HHA_RFRL	*Claim HHA Referral Code*
	Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for Home Health services.

Variable Name	*Label*
	NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces in this field. DB2 ALIAS: CLM_HHA_RFRL_CD SAS ALIAS: HHA_RFRL STANDARD ALIAS: CLM_HHA_RFRL_CD SYSTEM ALIAS: LTHRFRL TITLE ALIAS: HHA_REFERRAL_CODE CODES: REFER TO: CLM_HHA_RFRL_TB IN THE CODES APPENDIX SOURCE: CWF
VISITCNT	*Claim HHA Total Visit Count*
	Effective with Version H, the count of the number of HHA visits as derived by CWF. NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991) using the CWF derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X and 059X. Value '999' will be displayed if the sum of the revenue center unit count equals or exceeds '999'. NOTE2: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES. 3 DIGITS SIGNED DB2 ALIAS: HHA_TOT_VISIT_CNT SAS ALIAS: VISITCNT STANDARD ALIAS: CLM_HHA_TOT_VISIT_CNT TITLE ALIAS: HHA_TOT_VISITS SOURCE: CWF
QLFYFROM	*NCH Qualified Stay From Date*
	Effective with Version H, the beginning date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes). For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

Variable Name	*Label*	
		8 DIGITS UNSIGNED DB2 ALIAS: QLFY_STAY_FROM_DT SAS ALIAS: QLFYFROM STANDARD ALIAS: NCH_QLFY_STAY_FROM_DT TITLE ALIAS: QLFYG_STAY_FROM_DT EDIT-RULES: YYYYMMDD DERIVATION: DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_FROM_DT DERIVATION RULES: Based on the presence of occurrence code 70 move the related occurrence from date to NCH_QLFY_STAY_FROM_DT. SOURCE: NCH QA Process
QLFYTHRU	*NCH Qualify Stay Through Date*	
		Effective with Version H, the ending date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes.) For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'. NOTE: During the Version H, conversion this field was populated with data throughout history (back to service year 1991). 8 DIGITS UNSIGNED DB2 ALIAS: QLFY_STAY_THRU_DT SAS ALIAS: QLFYTHRU STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT TITLE ALIAS: QLFYG_STAY_THRU_DT EDIT-RULES: YYYYMMDD DERIVATION: DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_THRU_DT DERIVATION RULES: Based on the presence of occurrence code 70 move the related occurrence thru date to NCH_QLFY_STAY_THRU_DT. SOURCE: NCH QA Process
DSCHRGDT	*NCH Beneficiary Discharge Date*	
		Effective with Version H, on an inpatient and HHA claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.) NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991.)

Variable Name	*Label*
	8 DIGITS UNSIGNED DB2 ALIAS: NCH_BENE_DSCHRG_DT SAS ALIAS: DSCHRGDT STANDARD ALIAS: NCH_BENE_DSCHRG_DT TITLE ALIAS: DISCHARGE_DT EDIT-RULES: YYYYMMDD 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
HHSTRTDT	*Claim HHA Care Start Date*
	Effective with Version H, the date care started for the HHA services reported on the institutional claim with a from date greater than 3/31/98. The Balanced Budget Act (BBA) required that this field be present on all HHA claims. NOTE1: Beginning with NCH weekly process date 4/3/98, this field was populated with data. Claims processed prior to 4/3/98 will contain zeroes in this field. NOTE2: Effective with Version 'I', the start of care date will be moved from the 1st eight positions of the Claim Treatment Authorization Number. Prior to Version 'I' this date was moved from Occurrence Code 27 date field. 8 DIGITS UNSIGNED DB2 ALIAS: HHA_CARE_STRT_DT SAS ALIAS: HHSTRTDT STANDARD ALIAS: CLM_HHA_CARE_STRT_DT TITLE ALIAS: HHA_CARE_START_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
EDTND{x}	*NCH Edit Trailer Indicator Code*
where { x } ranges from 1 to 13	
	Effective with Version H, the code indicating the presence of an NCH edit trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: EDIT_TRLR_IND_CD SAS ALIAS: EDITIND STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD CODES: E = Edit code trailer present SOURCE: NCH QA Process

Variable Name	*Label*

EDITCD{x} — *NCH Edit Code*

where { x } ranges from 1 to 13

The code annotated to the claim indicating the CWFMQA editing results so users will
be aware of data deficiencies.
NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.
COMMON ALIAS: QA_ERROR_CODE
DB2 ALIAS: NCH_EDIT_CD
SAS ALIAS: EDIT_CD
STANDARD ALIAS: NCH_EDIT_CD
TITLE ALIAS: QA_ERROR_CD
CODES:
REFER TO: NCH_EDIT_TB
IN THE CODES APPENDIX
SOURCE:
NCH QA EDIT PROCESS

PTCHND{x} — *NCH Patch Trailer Indicator Code*

where { x } ranges from 1 to 30

Effective with Version H, the code indicating the presence of an NCH patch trailer.
NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
DB2 ALIAS: PATCH_TRLR_IND_CD
SAS ALIAS: PATCHIND
STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD
CODES:
P = Patch code trailer present
SOURCE:
NCH

PTCHCD{x} — *NCH Patch Code*

where { x } ranges from 1 to 30

Effective with Version H, the code annotated to the claim indicating a patch was applied
to the record during an NCH Nearline record conversion and/or during current processing.
NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.
DB2 ALIAS: NCH_PATCH_CD
SAS ALIAS: PATCHCD
STANDARD ALIAS: NCH_PATCH_CD
TITLE ALIAS: NCH_PATCH
CODES:
REFER TO: NCH_PATCH_TB
IN THE CODES APPENDIX
SOURCE:
NCH

PTCHDT{x} — *NCH Patch Applied Date*

where { x } ranges from 1 to 30

Variable Name	*Label*
	Effective with Version H, the date the NCH patch was applied to the claim. 8 DIGITS UNSIGNED DB2 ALIAS: NCH_PATCH_APPLY_DT SAS ALIAS: PATCHDT STANDARD ALIAS: NCH_PATCH_APPLY_DT TITLE ALIAS: NCH_PATCH_DT EDIT-RULES: YYYYMMDD SOURCE: NCH
MCOIND{x}	*NCH MCO Trailer Indicator Code*
where { x } ranges from 1 to 2	
	Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. COBOL ALIAS: MCO_IND DB2 ALIAS: MCO_TRLR_IND_CD SAS ALIAS: MCOIND STANDARD ALIAS: NCH_MCO_TRLR_IND_CD TITLE ALIAS: MCO_INDICATOR CODES: M = MCO trailer present SOURCE: NCH QA Process
MCONUM{x}	*MCO Contract Number*
where { x } ranges from 1 to 2	
	Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO). NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MCO_CNTRCT_NUM SAS ALIAS: MCONUM STANDARD ALIAS: MCO_CNTRCT_NUM TITLE ALIAS: MCO_NUM SOURCE: CWF
MCOOPTN{x}	*MCO Option Code*
where { x } ranges from 1 to 2	
	Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MCO_OPTN_CD SAS ALIAS: MCOOPTN STANDARD ALIAS: MCO_OPTN_CD

Variable Name	Label
	TITLE ALIAS: MCO_OPTION_CD CODES: *****For lock-in beneficiaries**** A = HCFA to process all provider bills B = MCO to process only in-plan C = MCO to process all Part A and Part B bills ***** For non-lock-in beneficiaries***** 1 = HCFA to process all provider bills 2 = MCO to process only in-plan Part A and Part B bills SOURCE: CWF
MCFFDT{x}	*MCO Period Effective Date*
where { x } ranges from 1 to 2	
	Effective with Version H, the date the bene- ficiary's enrollment in the Managed Care Organization (MCO) became effective. NOTE: 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. 8 DIGITS UNSIGNED DB2 ALIAS: MCO_PRD_EFCTV_DT SAS ALIAS: MCOEFFDT STANDARD ALIAS: MCO_PRD_EFCTV_DT TITLE ALIAS: MCO_PERIOD_EFF_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
MCTRMDT{x}	*MCO Period Termination Date*
where { x } ranges from 1 to 2	
	Effective with Version H, the date the bene- ficiary's enrollment in the Managed Care Organization (MCO) was terminated. NOTE: 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. 8 DIGITS UNSIGNED DB2 ALIAS: MCO_PRD_TRMNTN_DT SAS ALIAS: MCOTRMDT STANDARD ALIAS: MCO_PRD_TRMNTN_DT TITLE ALIAS: MCO_PERIOD_TERM_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
MCPLND{x}	*MCO Health PLANID Number*
where { x } ranges from 1 to 2	
	A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named:

Variable Name	Label
	MCO_PAYERID_NUM. DB2 ALIAS: MCO_PLANID_NUM SAS ALIAS: MCOPLNID STANDARD ALIAS: MCO_HLTH_PLANID_NUM TITLE ALIAS: MCO_PLANID COMMENT: Prior to Version I this field was named: MCO_PAYERID_NUM. SOURCE: CWF
PLNDND{x}	*NCH Health PlanID Trailer Indicator Code*
where { x } ranges from 1 to 3	
	A placeholder field (effective with Version H) for storing the code that indicates the presence of a Health PlanID trailer. NOTE: Prior to Version 'I' this field was named: NCH_PAYERID_TRLR_IND_CD. DB2 ALIAS: PLANID_TRLR_CD SAS ALIAS: PLANIDIN STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD CODES: I = Health PlanID trailer present COMMENT: Prior to Version I this field was named: NCH_PAYERID_TRLR_IND_CD. SOURCE: NCH
PLNDCD{x}	*Claim Health PlanID Code*
where { x } ranges from 1 to 3	
	A placeholder field (effective with Version H) for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID-CD DB2 ALIAS: CLM_PLANID_CD SAS ALIAS: PLANIDCD STANDARD ALIAS: CLM_HLTH_PLANID_CD TITLE ALIAS: PLANID_TYPE CODES: 1 = Medicare Secondary Payer 2 = Medicaid 3 = Medigap 4 = Supplemental Insurer 5 = Managed Care Organization COMMENT: Prior to Version I this field was named: CLM_PAYERID_CD. SOURCE: CWF
PLANID{x}	*Claim Health PlanID Number*
where { x } ranges from 1 to 3	
	A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version 'I' this field was named: CLM_PAYERID_NUM. DB2 ALIAS: CLM_PLANID_NUM

Variable Name	Label
	SAS ALIAS: PLANID STANDARD ALIAS: CLM_HLTH_PLANID_NUM TITLE ALIAS: PLANID COMMENT: Prior to Version I this field was named: CLM_PAYERID_NUM. SOURCE: CWF
DEMOIND{x}	*NCH Demonstration Trailer Indicator Code*
where { x } ranges from 1 to 5	
	Effective with Version H, the code indicating the presence of a demo trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). COBOL ALIAS: DEMO_IND DB2 ALIAS: DEMO_TRLR_IND_CD SAS ALIAS: DEMOIND STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD TITLE ALIAS: DEMO_INDICATOR CODES: D = Demo trailer present SOURCE: NCH
DEMONUM{x}	*Claim Demonstration Identification Number*
where { x } ranges from 1 to 5	
	Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN). NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria). 01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series. NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim. NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G). 02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two

Variable Name	*Label*

	alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.
	NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/ CHPP-supplied listing of provider # and start/ stop dates of participants.
	NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.
	03 = Telemedicine Demo -- testing covering tradi- tionally noncovered physician services for medical consultation furnished via two-way, inter- active video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.
	NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96) -- since 7/97, CWF has been adding Demo ID '03' to claim.
	NOTE2: During Version H conversion, Demo ID '03' was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.
	04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 desig- nated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.
	NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.
	05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.
	NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presences of the MCO Plan Contract #.
	NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross- walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').
	06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global

Variable Name	Label
	pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'. NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. Demo ID '06' will end once Demo ID '07' is implemented. NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates. 07 = Participating Centers of Excellence (PCOE) Demo -- testing a negotiated all-inclusive pricing arrangement (bundled rates) for high-cost acute care cardiovascular and orthopedic procedures performed in 60-100 premier facilities in the Chicago and San Francisco Regions or by current CABG providers. The inpatient claims will contain a DRG '104','105','106', '107','112','124','125','209',or '471'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'. NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '07' to claim. 08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo. NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim. 15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient

Variable Name	*Label*
	treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site. NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #. 30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH. NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only). 31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File). 37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Part A and Part B. There will be at least 9 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services. NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '37' to claim. 38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. **NOT IN NCH -- AVAILABLE IN NMUD.** NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims. 39 = Centralized Billing of Flu and PPV Claims -- The

Variable Name	*Label*
	purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing. NOTE: Effective October, 2000 for carrier claims. DB2 ALIAS: CLM_DEMO_ID_NUM SAS ALIAS: DEMONUM STANDARD ALIAS: CLM_DEMO_ID_NUM TITLE ALIAS: DEMO_ID SOURCE: CWF
DEMOTXT{x}	*Claim Demonstration Information Text*
where { x } ranges from 1 to 5	
	Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. NOTE: During the Version H conversion this field was populated with data throughout history. DB2 ALIAS: CLM_DEMO_INFO_TXT SAS ALIAS: DEMOTXT STANDARD ALIAS: CLM_DEMO_INFO_TXT TITLE ALIAS: DEMO_INFO DERIVATION: DERIVATION RULES: Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position. Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'. Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'. Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'. Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will re-

Variable Name	Label

flect 'INVALID'.
NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.
Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.
Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'.
SOURCE:
CWF

DGNSND{x} — *NCH Diagnosis Trailer Indicator Code*

where { x } ranges from 1 to 10

Effective with Version H, the code indicating the presence of a diagnosis trailer.
NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
DB2 ALIAS: DGNS_TRLR_IND_CD
SAS ALIAS: DGNSIND
STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD
CODES:
Y = Diagnosis code trailer present
SOURCE:
NCH

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: DGNS_CD
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.

CNDND{x} — *NCH Condition Trailer Indicator Code*

where { x } ranges from 1 to 30

Effective with Version H, the code indicating the presence of a condition code trailer.
NOTE: During the Version H conversion this field

Variable Name	*Label*
	was populated throughout history (back to service year 1991). DB2 ALIAS: COND_TRLR_IND_CD SAS ALIAS: CONDIND STANDARD ALIAS: NCH_COND_TRLR_IND_CD CODES: C = Condition code trailer present SOURCE: NCH
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: RLT_COND 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
OCRCND{x}	*NCH Occurrence Trailer Indicator Code*
where { x } ranges from 1 to 30	
	Effective with Version H, the code indicating the presence of a occurrence code trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: OCRNC_TRLR_IND_CD SAS ALIAS: OCRNCIND STANDARD ALIAS: NCH_OCRNC_TRLR_IND_CD CODES: O = Occurrence code trailer present SOURCE: NCH
OCRCCD{x}	*Claim Related Occurrence Code*
where { x } ranges from 1 to 30	

Variable Name	*Label*
	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: OCRNC_CD 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. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_RLT_OCRNC_DT SAS ALIAS: OCRNCDT STANDARD ALIAS: CLM_RLT_OCRNC_DT TITLE ALIAS: RLT_OCRNC_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
SPNND{x}	*NCH Span Trailer Indicator Code*
where { x } ranges from 1 to 10	
	Effective with Version H, the code indicating the presence of a span code trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: SPAN_TRLR_IND_CD SAS ALIAS: SPANIND STANDARD ALIAS: NCH_SPAN_TRLR_IND_CD CODES: S = Span code trailer present SOURCE: NCH
SPANCD{x}	*Claim Occurrence Span Code*
where { x } ranges from 1 to 10	
	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 time period (span of dates).

Variable Name	*Label*
	DB2 ALIAS: CLM_OCRNC_SPAN_CD SAS ALIAS: SPAN_CD STANDARD ALIAS: CLM_OCRNC_SPAN_CD SYSTEM ALIAS: LTSPAN TITLE ALIAS: SPAN_CD CODES: REFER TO: CLM_OCRNC_SPAN_TB IN THE CODES APPENDIX SOURCE: CWF
SPNFRM{x}	*Claim Occurrence Span From Date*
where { x } ranges from 1 to 10	
	The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing. 8 DIGITS UNSIGNED DB2 ALIAS: OCRNC_SPAN_FROM_DT SAS ALIAS: SPANFROM STANDARD ALIAS: CLM_OCRNC_SPAN_FROM_DT TITLE ALIAS: SPAN_FROM_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
SPNTHR{x}	*Claim Occurrence Span Through Date*
where { x } ranges from 1 to 10	
	The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing. 8 DIGITS UNSIGNED DB2 ALIAS: OCRNC_SPAN_THRU_DT SAS ALIAS: SPANTHRU STANDARD ALIAS: CLM_OCRNC_SPAN_THRU_DT TITLE ALIAS: SPAN_THRU_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
VALIND{x}	*NCH Value Trailer Indicator Code*
where { x } ranges from 1 to 36	
	Effective with Version H, the code indicating the presence of a value code trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: VAL_TRLR_IND_CD SAS ALIAS: VALIND STANDARD ALIAS: NCH_VAL_TRLR_IND_CD CODES: V = Value code trailer present SOURCE: NCH

Variable Name	Label

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: VAL_AMT
STANDARD ALIAS: CLM_VAL_AMT
TITLE ALIAS: VALUE_AMOUNT
EDIT-RULES:
$$$$$$$$$CC
SOURCE:
CWF

REVIND{x} — *NCH Revenue Center Trailer Indicator Code*

where { x } ranges from 1 to 58

Effective with Version H, the code identifying the revenue center trailer.
During the Version H conversion this field was populated with data throughout history (back to service year 1991).
DB2 ALIAS: REV_CNTR_TRLR_CD
SAS ALIAS: REVIND
STANDARD ALIAS: NCH_REV_CNTR_TRLR_IND_CD
CODES:
R = Revenue code trailer present
SOURCE:
NCH

RVCNTR{x} — *Revenue Center Code*

where { x } ranges from 1 to 58

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.

Variable Name	Label
	COBOL ALIAS: REV_CD DB2 ALIAS: REV_CNTR_CD SAS ALIAS: REV_CNTR 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 58

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.
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
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE
EDIT-RULES:
YYYYMMDD
SOURCE:
CWF

RVNS1{x}	*Revenue Center 1st ANSI Code*

where { x } ranges from 1 to 58

The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).
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

Variable Name	*Label*
	spaces in this field. DB2 ALIAS: REV_CNTR_ANSI1_CD SAS ALIAS: REVANSI1 STANDARD ALIAS: REV_CNTR_ANSI_1_CD SYSTEM ALIAS: LTANSI TITLE ALIAS: ANSI_CD CODES: REFER TO: REV_CNTR_ANSI_TB IN THE CODES APPENDIX SOURCE: CWF
RVNS2{x}	*Revenue Center 2nd ANSI Code*
where { x } ranges from 1 to 58	
	The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). 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_CNTR_ANSI2_CD SAS ALIAS: REVANSI2 STANDARD ALIAS: REV_CNTR_ANSI_2_CD TITLE ALIAS: ANSI_CD SOURCE: CWF
RVNS3{x}	*Revenue Center 3rd ANSI Code*
where { x } ranges from 1 to 58	
	The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). 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_CNTR_ANSI3_CD SAS ALIAS: REVANSI3 STANDARD ALIAS: REV_CNTR_ANSI_3_CD TITLE ALIAS: ANSI_CD SOURCE: CWF
RVNS4{x}	*Revenue Center 4th ANSI Code*
where { x } ranges from 1 to 58	
	The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). 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_CNTR_ANSI4_CD SAS ALIAS: REVANSI4 STANDARD ALIAS: REV_CNTR_ANSI_4_CD TITLE ALIAS: ANSI_CD SOURCE:

Variable Name	Label
	CWF
APCPPS{x}	*Revenue Center APC/HIPPS Code*

where { x } ranges from 1 to 58

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: APCHIPPS
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 System Code*

where { x } ranges from 1 to 58

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: HCPCS_CD
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)

Variable Name	Label
	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 purposes. 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.
MDFCD1{x}	*Revenue Center HCPCS Initial Modifier Code*
where { x } ranges from 1 to 58	
	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: MDFR_CD1 STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD TITLE ALIAS: INITIAL_MODIFIER

Variable Name	*Label*
	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
MDFCD2{x}	*Revenue Center HCPCS Second Modifier Code*
where { x } ranges from 1 to 58	
	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: MDFR_CD2 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
MDFCD3{x}	*Revenue Center HCPCS Third Modifier Code*
where { x } ranges from 1 to 58	
	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: MDFR_CD3 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
MDFCD4{x}	*Revenue Center HCPCS Fourth Modifier Code*
where { x } ranges from 1 to 58	
	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

Variable Name	*Label*
	SAS ALIAS: MDFR_CD4 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
MDFCD5{x}	*Revenue Center HCPCS Fifth Modifier Code*
where { x } ranges from 1 to 58	
	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: MDFR_CD5 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 58	
	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: PMTMTHD 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
DSCTND{x}	*Revenue Center Discount Indicator Code*
where { x } ranges from 1 to 58	

Variable Name	Label
	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 dis-counting 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: DSCNTIND 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}	*Revenue Center Packaging Indicator Code*
where { x } ranges from 1 to 58	
	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: PACKGIND STANDARD ALIAS: REV_CNTR_PACKG_IND_CD SYSTEM ALIAS: LTPACKG TITLE ALIAS: REV_CNTR_PACKG_IND 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 58	

Variable Name	*Label*
	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
OTAF_1{x}	*Revenue Center Obligation to Accept As Full (OTAF) Payment*
where { x } ranges from 1 to 58	
	Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount re- ceived 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: OTAF_1 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
OTAF_2{x}	*Revenue Center Obligation to Accept As Full (OTAF) Payment*
where { x } ranges from 1 to 58	
	**********FIELD NOT POPULATED********** This field was intended to collect information for two payers if Medicare was tertiary. It was discovered that MSP system only deals with one payer so there is no need to have 2 OTAF fields. DB2 ALIAS: REV_OTAF2_IND_CD SAS ALIAS: OTAF_2 STANDARD ALIAS: REV_CNTR_OTAF_2_IND_CD TITLE ALIAS: REV_CNTR_OTAF_2_IND_CD SOURCE: CWF

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

where { x } ranges from 1 to 58

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 conversion 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 process 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

RVUNT{x}	*Revenue Center Unit Count*

where { x } ranges from 1 to 58

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 described 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 HIPPS code and, if applicable, the number of visits for each rehab therapy code.

Variable Name	Label
	7 DIGITS SIGNED DB2 ALIAS: REV_CNTR_UNIT_CNT SAS ALIAS: REV_UNIT STANDARD ALIAS: REV_CNTR_UNIT_CNT TITLE ALIAS: UNITS SOURCE: CWF
RVRT{x}	*Revenue Center Rate Amount*
where { x } ranges from 1 to 58	
	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: REV_RATE STANDARD ALIAS: REV_CNTR_RATE_AMT TITLE ALIAS: CHARGE_PER_UNIT 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 58	
	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.

Variable Name	*Label*
	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: REVBLOOD STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT TITLE ALIAS: BLOOD_DDCTBL_AMT SOURCE: CWF
RVDTBL{x}	*Revenue Center Cash Deductible Amount*
where { x } ranges from 1 to 58	
	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: REVDCTBL STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT TITLE ALIAS: CASH_DDCTBL SOURCE: CWF
WGDJ{x}	*Revenue Center Coinsurance/Wage Adjusted Coinsurance*
where { x } ranges from 1 to 58	
	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: WAGEADJ STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT TITLE ALIAS: WAGE_ADJSTD_COINS SOURCE: CWF

Variable Name	*Label*

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

where { x } ranges from 1 to 58

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: RDCDCOIN
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS: REDUCED_COINS
SOURCE:
CWF

RVMSP1{x} — *Revenue Center 1st Medicare Secondary Payer Paid Amount*

where { x } ranges from 1 to 58

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: REV_MSP1
STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT
SOURCE:
CWF

RVMSP2{x} — *Revenue Center 2nd Medicare Secondary Payer Paid Amount*

where { x } ranges from 1 to 58

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: REV_MSP2
STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT
SOURCE:
CWF

Variable Name	*Label*

RVPCHG{x} — *Revenue Center Professional Component Amount*

where { x } ranges from 1 to 58

**********FIELD NOT POPULATED********** Intended to be populated for line item services subject to PPS, as the amount associated with
Value Code '05'. However, with line item date of service reporting, there is no way to correctly allocate professional component charges reported in value code '05' to specific line items on the claim.
9.2 DIGITS SIGNED
DB2 ALIAS: REV_PROFNL_CMPNT
SAS ALIAS: REVPCCHG
STANDARD ALIAS: REV_CNTR_PROFNL_CMPNT_AMT
TITLE ALIAS: PROFNL_CMPNT_CHARGES
SOURCE:
CWF

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

where { x } ranges from 1 to 58

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: RPRVDPMT
STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
TITLE ALIAS: REV_PRVDR_PMT
SOURCE:
CWF

RBNPMT{x} — *Revenue Center Beneficiary Payment Amount*

where { x } ranges from 1 to 58

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: RBENEPMT
STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
TITLE ALIAS: REV_BENE_PMT
SOURCE:
CWF

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

where { x } ranges from 1 to 58

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.

Variable Name	Label
	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: PTNTRESP STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT TITLE ALIAS: REV_PTNT_RESP SOURCE: CWF
REVPMT{x}	*Revenue Center Payment Amount*
where { x } ranges from 1 to 58	
	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: $$$$$$$$$CC SOURCE: CWF
RVCHRG{x}	*Revenue Center Total Charge Amount*
where { x } ranges from 1 to 58	
	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 deductible and 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 revenue 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 center 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 total charges will be $1 (rate) times units (days). 9.2 DIGITS SIGNED DB2 ALIAS: REV_TOT_CHRG_AMT SAS ALIAS: REV_CHRG STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT TITLE ALIAS: REVENUE_CENTER_CHARGES EDIT-RULES: $$$$$$$$$CC COMMENT: Prior to Version H the size of this field was: S9(7)V99. SOURCE: CWF
RVNCVR{x}	*Revenue Center Non-Covered Charge Amount*
where { x } ranges from 1 to 58	
	The charge amount related to a revenue center code for services that are not covered by Medicare. NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types. 9.2 DIGITS SIGNED DB2 ALIAS: REV_NCVR_CHRG_AMT SAS ALIAS: REV_NCVR STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES EDIT-RULES: $$$$$$$$$CC SOURCE: CWF
RVDDCD{x}	*Revenue Center Deductible Coinsurance Code*
where { x } ranges from 1 to 58	
	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. DB2 ALIAS: DDCTBL_COINSRNC_CD SAS ALIAS: REVDEDCD STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD CODES: REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB IN THE CODES APPENDIX SOURCE: CWF
EOR	*End of Record Code*
	Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim. DB2 ALIAS: END_REC_CD SAS ALIAS: EOR

Variable Name	*Label*	
		STANDARD ALIAS: END_REC_CD TITLE ALIAS: END_OF_REC CODES: EOR = End of Record/Segment EOC= End of Claim COMMENT: Prior to Version I this field was named: END_REC_CNSTNT. SOURCE: NCH