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

Variable Name	***Label***

DESY_SORT_KEY — *DESY SORT KEY*

This field contains the key to link data for each beneficiary across all claim files.

REC_LVL — *NCH Near-Line Record Version Code*

The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored:

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

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

RIC_CD — *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
IN THE CODES APPENDIX

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

SOURCE:
NCH

CLM_TYPE — *NCH Claim Type Code*

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

NOTE1: During the Version H conversion this field was

Variable Name	*Label*
	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: UTLHHAI_NCH_CLM_TYPE_CD SYSTEM ALIAS: LTTYPE TITLE ALIAS: CLAIM_TYPE DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD. PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE

Variable Name	*Label*	
		DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD DERIVATION RULES: SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U' 2. PMT_EDIT_RIC_CD EQUAL 'F' 3. CLM_TRANS_CD EQUAL '5' SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '0' OR '4' 4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y' OR 'Z' SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '0' OR '4' 4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y' OR 'Z' SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'W' 2. PMT_EDIT_RIC_CD EQUAL 'D' 3. CLM_TRANS_CD EQUAL '6' SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'W' 2. PMT_EDIT_RIC_CD EQUAL 'D' 3. CLM_TRANS_CD EQUAL '6' 4. FI_NUM = 80881 SET CLM_TYPE_CD TO 42 (OUTPATIENT ENCOUNTER CLAIMS -- AVAILABLE IN NMUD) 1. FI_NUM = 80881 2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_ CLSFCTN_TYPE_CD = '2', '3' OR '4' & CLM_FREQ_CD = 'Z', 'Y' OR 'X' SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'I' 3. CLM_TRANS_CD EQUAL 'H' SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

Variable Name	*Label*
	1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '1' '2' OR '3' SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_MCO_PD_SW = '1' 2. CLM_RLT_COND_CD = '04' 3. MCO_CNTRCT_NUM MCO_OPTN_CD = 'C' CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT ENROLLMENT PERIODS SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '1' '2' OR '3' 4. FI_NUM = 80881 SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. FI_NUM = 80881 AND 2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_ TYPE_CD = '1'; CLM_FREQ_CD = 'Z' SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD not on DMEPOS table SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table). SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38 SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table

Variable Name	Label
	SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table). CODES: REFER TO: NCH_CLM_TYPE_TB IN THE CODES APPENDIX SOURCE: NCH
STATE_CD	*Beneficiary Residence SSA Standard State Code*
	The SSA standard state code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_STATE_CODE DB2 ALIAS: BENE_SSA_STATE_CD SAS ALIAS: STATE_CD STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD TITLE ALIAS: BENE_STATE_CD EDIT-RULES: OPTIONAL: MAY BE BLANK CODES: REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX COMMENT: 1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement. 2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish. 3. Also used for special studies. SOURCE: SSA/EDB
THRU_DT	*Claim Through Date*
	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date'). For the Limited Data Set Standard View of the HHA files, the claim through date is coded as the quarter of the calendar year when the claim through date occurred. NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match. 8 DIGITS UNSIGNED

Variable Name	Label
	DB2 ALIAS: CLM_THRU_DT SAS ALIAS: THRU_DT STANDARD ALIAS: CLM_THRU_DT TITLE ALIAS: THRU_DATE EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR SOURCE: CWF
QUERY_CD	*Claim Query Code*
	Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator). DB2 ALIAS: CLM_QUERY_CD SAS ALIAS: QUERY_CD STANDARD ALIAS: CLM_QUERY_CD TITLE ALIAS: QUERY_CD CODES: 0 = Credit adjustment 1 = Interim bill 2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98) 3 = Final bill 4 = Discharge notice (obsolete 7/98) 5 = Debit adjustment SOURCE: CWF
PROVIDER	*Provider Number*
	The identification number of the institutional provider certified by Medicare to provide services to the beneficiary. DB2 ALIAS: PRVDR_NUM SAS ALIAS: PROVIDER STANDARD ALIAS: PRVDR_NUM TITLE ALIAS: PROVIDER_NUMBER CODES: REFER TO: PRVDR_NUM_TB IN THE CODES APPENDIX SOURCE: OSCAR

Variable Name	Label
SGMT_CNT	*Claim Total Segment Count*

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

SGMT_NUM	*Claim Segment Number*

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

PE_RIC	*NCH Payment and Edit Record Identification Code*

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

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

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

SOURCE:
NCH QA Process

Variable Name	Label
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 claim in the beneficiary's current episode of care.

Variable Name	*Label*
	COMMON ALIAS: TOB3 DB2 ALIAS: CLM_FREQ_CD SAS ALIAS: FREQ_CD STANDARD ALIAS: CLM_FREQ_CD SYSTEM ALIAS: LTFREQ TITLE ALIAS: FREQUENCY_CD CODES: REFER TO: CLM_FREQ_TB IN THE CODES APPENDIX SOURCE: CWF
CNTY_CD	*Beneficiary Residence SSA Standard County Code* The SSA standard county code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_COUNTY_CODE DB2 ALIAS: BENE_SSA_CNTY_CD SAS ALIAS: CNTY_CD STANDARD ALIAS: TITLE ALIAS: BENE_COUNTY_CD EDIT-RULES: OPTIONAL: MAY BE BLANK SOURCE: SSA/EDB
FI_NUM	*FI Number* The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records. DB2 ALIAS: FI_NUM SAS ALIAS: FI_NUM STANDARD ALIAS: FI_NUM SYSTEM ALIAS: LTFI TITLE ALIAS: INTERMEDIARY CODES: REFER TO: FI_NUM_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: FICARR_IDENT_NUM. SOURCE: CWF
SEX	*Beneficiary Sex Identification Code* The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD SAS ALIAS: SEX STANDARD ALIAS: BENE_SEX_IDENT_CD SYSTEM ALIAS: LTSEX

Variable Name	*Label*	
		TITLE ALIAS: SEX_CD EDIT-RULES: REQUIRED FIELD CODES: 1 = Male 2 = Female 0 = Unknown SOURCE: SSA,RRB,EDB
RACE	*Beneficiary Race Code*	
		The race of a beneficiary. DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD SAS ALIAS: RACE STANDARD ALIAS: BENE_RACE_CD SYSTEM ALIAS: LTRACE TITLE ALIAS: RACE_CD CODES: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = North American Native SOURCE: SSA
BENE_DOB	*Beneficiary Birth Date*	
		The beneficiary's date of birth. For the Limited Data Set Standard View of the HHA files, the beneficiary's date of birth (age) is coded as a range. 8 DIGITS UNSIGNED DB2 ALIAS: BENE_BIRTH_DT SAS ALIAS: BENE_DOB STANDARD ALIAS: BENE_BIRTH_DT TITLE ALIAS: BENE_BIRTH_DATE EDIT-RULES FOR ENCRYPTED DATA: 0000000R WHERE R HAS ONE OF THE FOLLOWING VALUES. 0 = Unknown 1 = <65 2 = 65 Thru 69 3 = 70 Thru 74 4 = 75 Thru 79 5 = 80 Thru 84 6 = >84

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

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

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

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

SOURCE:
CWF

Variable Name	*Label*
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 be chiefly responsible for the services provided.

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

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

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

NOPAY_CD	*Claim Medicare Non Payment Reason Code*

The reason that no Medicare payment is made for services on an institutional claim.
NOTE: Effective with Version I, this field was put on all institutional claim types.
Prior to Version I, this field was present only on inpatient/SNF claims.

DB2 ALIAS: MDCR_NPMT_RSN_CD
SAS ALIAS: NOPAY_CD
STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
SYSTEM ALIAS: LTNPMT
TITLE ALIAS: NON_PAYMENT_REASON

EDIT-RULES:
OPTIONAL

CODES:
REFER TO: CLM_MDCR_NPMT_RSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

TRTMT_CD	*Claim Excepted/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:

Variable Name	*Label*
	TITLE ALIAS: EXCPTD_NEXCPTD_CD CODES: 0 = No Entry 1 = Excepted 2 = Nonexcepted SOURCE: CWF
PMT_AMT	*Claim Payment Amount* Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid daily per diem rate no matter what the charges are.) Under IP PPS, inpatient hospital services are paid based a predetermined rate per discharge, using the DRG classification system and the PRICER program. On the PPS claim, the payment amount includes the DRG approved payment amount, disproportionate share 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement. Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount. Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage adjustment and the beneficiary deductible and amounts. NOTE: There is no CWF edit check to validate the revenue center Medicare payment amount equals the claim level Medicare payment amount. Under Home Health PPS, beneficiaries will be classified

Variable Name	*Label*
	an appropriate case mix category known as the Home Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG). For the RAP, the PRICER will determine the payment appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case episode payment. The payment is then wage index For the final claim, PRICER calculates 100% of the due, because the final claim is processed as an to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider actually receive the 40% or 50% payment. Exceptions: For claims involving demos and BBA data, the amount reported in this field may not just represent the actual provider payment. For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included. For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO. For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo. For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan. 9.2 DIGITS SIGNED COMMON ALIAS: REIMBURSEMENT DB2 ALIAS: CLM_PMT_AMT SAS ALIAS: PMT_AMT STANDARD ALIAS: CLM_PMT_AMT TITLE ALIAS: REIMBURSEMENT EDIT-RULES: +9(9).99 COMMENT: Prior to Version H the size of this field was S9(7)V99. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

Variable Name	Label
	SOURCE: CWF LIMITATIONS: Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.
PRPAYAMT	*NCH Primary Payer Claim Paid Amount*
	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that theprovider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim. 9.2 DIGITS SIGNED DB2 ALIAS: PRMRY_PYR_PD_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT EDIT-RULES: +9(9).99 COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99. SOURCE: NCH
PRPAY_CD	*NCH Primary Payer Code*
	The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills. DB2 ALIAS: NCH_PRMRY_PYR_CD SAS ALIAS: PRPAY_CD STANDARD ALIAS: NCH_PRMRY_PYR_CD TITLE ALIAS: PRIMARY_PAYER_CD DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT DERIVATION RULES SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE CLM_VAL_CD = '12'

Variable Name	Label
	SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE CLM_VAL_CD = '13' SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14' SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15' SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT not equal to zeroes) SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43' SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM_VAL_CD = '41' SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE CLM_VAL_CD = '42' SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97 set code to 'J') WHERE THE CLM_VAL_CD = '47' CODES: REFER TO: BENE_PRMRY_PYR_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CD. SOURCE: NCH
CANCELCD	*FI Requested Claim Cancel Reason Code*
	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*

Variable Name	*Label*
	The type of action requested by the intermediary to be taken on an institutional claim. DB2 ALIAS: FI_CLM_ACTN_CD SAS ALIAS: ACTIONCD STANDARD ALIAS: FI_CLM_ACTN_CD TITLE ALIAS: ACTION_CD CODES: REFER TO: FI_CLM_ACTN_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: INTRMDRY_CLM_ACTN_CD. SOURCE: CWF
PRSTATE	*NCH Provider State Code* Effective with Version H, the two position SSA state code where provider facility is located. NOTE: During the Version H conversion this field was populated with data throughout history (back to service 1991). DB2 ALIAS: NCH_PRVDR_STATE_CD SAS ALIAS: PRSTATE STANDARD ALIAS: NCH_PRVDR_STATE_CD TITLE ALIAS: PROVIDER_STATE_CD DERIVATION: DERIVED FROM: NCH PRVDR_NUM DERIVATION RULES: SET NCH_PRVDR_STATE_CD TO PRVDR_NUM POS1-2. FOR PRVDR_NUM POS1-2 EQUAL '55 SET NCH_PRVDR_STATE_CD TO '05'. FOR PRVDR_NUM POS1-2 EQUAL '67 SET NCH_PRVDR_STATE_CD TO '45'. FOR PRVDR_NUM POS1-2 EQUAL '68 SET NCH_PRVDR_STATE_CD TO '10'. CODES: REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX SOURCE: NCH
AT_UPIN	*Claim Attending Physician UPIN Number* On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary

Variable Name	Label
	responsibility for the beneficiary's medical care and treatment (attending physician). This field is ENCRYPTED for the Limited Data Set Standard View of the HHA files. COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN DB2 ALIAS: ATNDG_UPIN SAS ALIAS: AT_UPIN STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM TITLE ALIAS: ATTENDING_PHYSICIAN COMMENT: Prior to Version H this field was named: CLM_PRMRY_CARE_PHYSN_IDENT_NUM and 10 positions (6-position UPIN and 4-position physician surname). SOURCE: CWF
OP_UPIN	*Claim Operating Physician UPIN Number* On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure. This field is ENCRYPTED for the Limited Data Set Standard View of the HHA files. DB2 ALIAS: OPRTG_UPIN SAS ALIAS: OP_UPIN STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM TITLE ALIAS: OPRTG_UPIN COMMENT: Prior to Version H this field was named: CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position physician surname. NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces. SOURCE: CWF
OT_UPIN	*Claim Other Physician UPIN Number* On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. This field is ENCRYPTED for the Limited Data Set Standard View of the HHA files.

Variable Name	Label

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

MCOPDSW — *Claim MCO Paid Switch*

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

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

CODES:
1 = MCO has paid the provider for a claim
Blank or 0 = MCO has not paid the provider for a claim

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

SOURCE:
CWF

STUS_CD — *Patient Discharge Status Code*

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

CODES:
REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

COMMENT:

Variable Name	Label
	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 pop-ulated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces. COBOL ALIAS: PPS_IND DB2 ALIAS: CLM_PPS_IND_CD SAS ALIAS: PPS_IND STANDARD ALIAS: CLM_PPS_IND_CD TITLE ALIAS: PPS_IND CODES: REFER TO: CLM_PPS_IND_TB IN THE CODES APPENDIX SOURCE: CWF
TOT_CHRG	*Claim Total Charge Amount*
	Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

Variable Name	Label
	9.2 DIGITS SIGNED DB2 ALIAS: CLM_TOT_CHRG_AMT SAS ALIAS: TOT_CHRG STANDARD ALIAS: CLM_TOT_CHRG_AMT TITLE ALIAS: CLAIM_TOTAL_CHARGES EDIT-RULES: +9(9).99 COMMENT: Prior to Version H the size of this field was S9(7)V99. SOURCE: CWF
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 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: Prior to Version H this field was named: CLM_OTHR_DGNS_CD_CNT and the principal was not included in the count. SOURCE: CWF
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 many 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: CWF

Variable Name	*Label*
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:
CWF

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 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:
CWF

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 revenue center trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_REV_CNTR_CD_CNT
SAS ALIAS: HHREVCNT
STANDARD ALIAS: HHA_REV_CNTR_CD_I_CNT

EDIT-RULES:
RANGE: 0 TO 45

COMMENT:

Variable Name	*Label*
	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, but in the conversion we made all claims back to service year 1991 contain only 45 revenue center lines. It is possible that claims prior to 1991 will have 2 segments if they contained more than 45 revenue lines. SOURCE: CWF
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 codes used to identify the means by which the beneficiary was referred for Home Health Services. 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

Variable Name	Label
	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 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 EDIT-RULES +999 SOURCE: CWF
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'. For the Limited Data Set Standard View of the HHA files, the beneficiary's qualifying stay through date is coded as the quarter of calendar year when the stay through date occurred.

Variable Name	Label
	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 FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR DERIVATION: DERIVED FROM: 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.) For the Limited Data Set Standard View of the HHA files, the beneficiary's discharge date is coded as the quarter of the calendar year when the discharge occurred. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991.) 8 DIGITS UNSIGNED DB2 ALIAS: NCH_BENE_DSCHRG_DT SAS ALIAS: DSCHRGDT STANDARD ALIAS: NCH_BENE_DSCHRG_DT TITLE ALIAS: DISCHARGE_DT EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR

Variable Name	*Label*

3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

DERIVATION:
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

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

SOURCE:
NCH QA Process

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.

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

Variable Name	Label
	over 18 years old 36 THRU 45 = Accommodation 46 THRU 54 = CHAMPUS information 55 THRU 59 = Skilled nursing facility 60 THRU 70 = Prospective payment 71 THRU 99 = Renal dialysis setting A0 THRU B9 = Special program codes C0 THRU C9 = PRO approval services D0 THRU W0 = Change conditions CODES: REFER TO: CLM_RLT_COND_TB IN THE CODES APPENDIX SOURCE: CWF
OCRCCD{x}	*Claim Related Occurrence Code*
where { x } ranges from 1 to 30	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date. DB2 ALIAS: CLM_RLT_OCRNC_CD SAS ALIAS: 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. For the Limited Data Set Standard View of the HHA files, the claim related occurrence date is coded as the quarter of the calendar year when the related occurrence occurred.

Variable Name	*Label*

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

SOURCE:
CWF

VAL_CD{x} *Claim Value Code*

where { x } ranges from 1 to 36

The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.

DB2 ALIAS: CLM_VAL_CD
SAS ALIAS: VAL_CD
STANDARD ALIAS: CLM_VAL_CD
SYSTEM ALIAS: LTVALUE
TITLE ALIAS: VALUE_CD

CODES:
REFER TO: CLM_VAL_TB
IN THE CODES APPENDIX

SOURCE:
CWF

VALAMT{x} *Claim Value Amount*

where { x } ranges from 1 to 36

The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_VAL_AMT
SAS ALIAS: VAL_AMT
STANDARD ALIAS: CLM_VAL_AMT
TITLE ALIAS: VALUE_AMOUNT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

Variable Name	*Label*

RVCNTR{x} *Revenue Center Code*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

COBOL ALIAS: REV_CD
DB2 ALIAS: REV_CNTR_CD
SAS ALIAS: 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

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.

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

For the Limited Data Set Standard View of the HHA files, the date applicable to the service represented by the revenue center code is coded as the quarter of the calendar year when the service represented by the revenue center code occurred.

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

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

Variable Name	Label
	presents the MDS RAI assessment reference date. NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment. 8 DIGITS UNSIGNED DB2 ALIAS: REV_CNTR_DT SAS ALIAS: REV_DT STANDARD ALIAS: REV_CNTR_DT TITLE ALIAS: REV_CNTR_DATE EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR SOURCE: CWF
APCPPS{x} *where { x } ranges from 1 to 58*	*Revenue Center APC/HIPPS Code* If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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

Variable Name	*Label*
	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} *where { x } ranges from 1 to 58*	*Revenue Center HCFA Common Procedure Coding* If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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) 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.

Variable Name	*Label*
	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} *where { x } ranges from 1 to 58*	*Revenue Center HCPCS Initial Modifier Code* If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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: TITLE ALIAS: INITIAL_MODIFIER EDIT-RULES: Carrier Information File COMMENT: Prior to Version H this field was named: HCPCS_INITL_MDFR_CD. With Version H, a prefix was added to denote the location of this field

Variable Name	Label
	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	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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

Variable Name	*Label*

MDFCD4{x} *Revenue Center HCPCS Fourth Modifier Code*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures
performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_4TH_CD
SAS ALIAS: 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

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
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

Variable Name	*Label*

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

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
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

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC
discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. **If there is no discounting the factor will be 1.0.**

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

DB2 ALIAS: REV_DSCNT_IND_CD
SAS ALIAS: 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

Variable Name	Label
	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	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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

Variable Name	*Label*
	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)*
where { x } ranges from 1 to 58	
	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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
IDENDC{x}	*Revenue Center IDE, NDC, UPC Number*
where { x } ranges from 1 to 58	
	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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:

Variable Name	*Label*
	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} *where { x } ranges from 1 to 58*	*Revenue Center Unit Count* If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. A quantitative measure (unit) of the number of times the service or procedure being reported was performed to the revenue center/HCPCS code definition as an institutional claim. Depending on type of service, units are measured by of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests. NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each code and, if applicable, the number of visits for each rehab therapy code. 7 DIGITS SIGNED DB2 ALIAS: REV_CNTR_UNIT_CNT SAS ALIAS: REV_UNIT STANDARD ALIAS: REV_CNTR_UNIT_CNT TITLE ALIAS: UNITS EDIT-RULES:

Variable Name	*Label*
	+9(7) SOURCE: CWF
RVRT{x} *where { x } ranges from 1 to 58*	*Revenue Center Rate Amount* If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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 EDIT-RULES: +9(9).99 EFFECTIVE-DATE: 10/01/1993 COMMENT: Prior to Version H the size of this field was:

Variable Name	*Label*
	S9(7)V99. SOURCE: CWF
RVBLD{x}	*Revenue Center Blood Deductible Amount*
where { x } ranges from 1 to 58	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_BLOOD_DDCTBL SAS ALIAS: REVBLOOD STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT TITLE ALIAS: BLOOD_DDCTBL_AMT EDIT-RULES: +9(9).99 SOURCE: CWF
RVDTBL{x}	*Revenue Center Cash Deductible Amount*
where { x } ranges from 1 to 58	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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 EDIT-RULES: +9(9).99 SOURCE: CWF

Variable Name	*Label*
WGDJ{x}	*Revenue Center Coinsurance/Wage Adjusted*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
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

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RDCDCN{x}	*Revenue Center Reduced Coinsurance Amount*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
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

Variable Name	*Label*
	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 EDIT-RULES: +9(9).99 SOURCE: CWF
RVMSP1{x} *where { x } ranges from 1 to 58*	*Revenue Center 1st Medicare Secondary Payer Paid* If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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 EDIT-RULES: +9(9).99 SOURCE: CWF
RVMSP2{x} *where { x } ranges from 1 to 58*	*Revenue Center 2nd Medicare Secondary Payer Paid* If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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

Variable Name	*Label*
	STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT TITLE ALIAS: MSP PAID AMOUNT EDIT-RULES: +9(9).99 SOURCE: CWF
RPRPMT{x}	*Revenue Center Provider Payment Amount*
where { x } ranges from 1 to 58	
	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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 EDIT-RULES: +9(9).99 SOURCE: CWF
RBNPMT{x}	*Revenue Center Beneficiary Payment Amount*
where { x } ranges from 1 to 58	
	If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records. 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 EDIT-RULES: +9(9).99 SOURCE:

Variable Name	*Label*
	CWF
PTNRSP{x}	*Revenue Center Patient Responsibility Payment Amount*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

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

9.2 DIGITS SIGNED

DB2 ALIAS: REV_PTNT_RESP_AMT
SAS ALIAS: PTNTRESP
STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS: REV_PTNT_RESP

EDIT-RULES:
+9(9).99

SOURCE:
CWF

REVPMT{x} *Revenue Center Payment Amount*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC.

Under HH PPS, PRICER will compute/return a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: REV_CNTR_PMT_AMT
SAS ALIAS: REVPMT
STANDARD ALIAS: REV_CNTR_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
+9(9).99

SOURCE:

Variable Name	*Label*
	CWF
RVCHRG{x}	*Revenue Center Total Charge Amount*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the coinsurance amounts and before an adjustment for the cost of
services provided. NOTE: For accommodation revenue center
total charges must equal the rate times units (days).

EXCEPTIONS:
(1) For SNF RUGS demo claims only (9000 series center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code
= '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code =
'0023', the total charges will equal the dollar amount for the '0023' line.

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

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

9.2 DIGITS SIGNED

DB2 ALIAS: REV_TOT_CHRG_AMT
SAS ALIAS: REV_CHRG
STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS: REVENUE_CENTER_CHARGES

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

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

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
The charge amount related to a revenue center code for services that are not covered by Medicare.
NOTE: Prior to Version H the field size was S9(7)V99 the element was only present on the Inpatient/SNF As of NCH weekly process date 10/3/97 this field was to all institutional claim types.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_NCVR_CHRG_AMT
SAS ALIAS: REV_NCVR
STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT
TITLE ALIAS:

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVDDCD{x}	*Revenue Center Deductible Coinsurance Code*

where { x } ranges from 1 to 58

If segment count > 1 then revenue center trailer elements 46–58 are missing and trailers above 45 are in subsequent records.
Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.
DB2 ALIAS: DDCTBL_COINSRNC_CD
SAS ALIAS: REVDEDCD
STANDARD ALIAS:
TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

CODES:
REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF