Research Data Distribution Center
LDS Inpatient SNF 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

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

SOURCE:
NCH

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

Variable Name	Label

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 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
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

Variable Name	*Label*

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

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

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

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER

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

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

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

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

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE 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

Variable Name	Label

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
Inpatient/SNF files, the claim through
date is coded as the quarter of the
calendar year when the claim through
date occurred.

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

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT
SAS ALIAS: THRU_DT

Variable Name	*Label*

STANDARD ALIAS: CLM_THRU_DT
TITLE ALIAS: THRU_DATE

EDIT-RULES FOR LIMITED DATA SET 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

Variable Name	Label
	SOURCE:
	OSCAR

SGMT_CNT   *Claim Total Segment Count*

Effective with Version I, the count used to identify the total number of segments

associated with a given claim. Each claim
could have up to 10 segments.
2 DIGITS UNSIGNED
DB2 ALIAS: TOT_SGMT_CNT
SAS ALIAS: SGMT_CNT
STANDARD ALIAS: CLM_TOT_SGMT_CNT
TITLE ALIAS: SEGMENT_COUNT
SOURCE:
CWF

SGMT_NUM   *Claim Segment Number*

Effective with Version I, the number used to identify an actual record/segment (1 - 10)

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

PE_RIC   *NCH Payment and Edit Record Identification Code*

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_REC

CODES:
C = Inpatient hospital, SNF
D = Outpatient
E = Religious Nonmedical Health Care Institutions (eff. 8/00

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*

Variable Name	*Label*

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS: TOB2
DB2 ALIAS: SRVC_CLSFCTN_CD
SAS ALIAS: TYPESRVC
STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
TITLE ALIAS: TOB2

CODES:
REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
CWF

FREQ_CD   *Claim Frequency Code*

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a

claim in the beneficiary's current episode of care.

COMMON ALIAS: TOB3
DB2 ALIAS: CLM_FREQ_CD
SAS ALIAS: FREQ_CD
STANDARD ALIAS: CLM_FREQ_CD
SYSTEM ALIAS: LTFREQ
TITLE ALIAS: FREQUENCY_CD

CODES:
REFER TO: CLM_FREQ_TB
IN THE CODES APPENDIX

SOURCE:
CWF

CNTY_CD   *Beneficiary Residence SSA Standard County Code*

The SSA standard county code of a beneficiary's residence. DA3
ALIAS: SSA_STANDARD_COUNTY_CODE

DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

FI_NUM   *FI Number*

Variable Name	*Label*

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
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

Variable Name	*Label*

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 Inpatient/SNF files, the beneficiary's
date of birth 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 LIMITED DATA SET DATA:
0000000R
WHERE R HAS ONE OF THE FOLLOWING VALUES.
0 = Unknown
1 = <65
2 = 65 Thru 69
3 = 70 Thru 74
4 = 75 Thru 79
5 = 80 Thru 84
6 = >84

SOURCE:
CWF

MS_CD   *CWF Beneficiary Medicare Status Code*

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

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

Variable Name	*Label*

TITLE ALIAS: MSC

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

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

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

COMMENT:
Prior to Version H this field was named:

BENE_MDCR_STUS_CD. The name has been changed
to distinguish this CWF-derived field from the
EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

PDGNS_CD	*Claim Principal Diagnosis Code*

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

Variable Name	Label

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 re-
quired under Federal, State or local law. Nonexcepted is
defined as medical care or treatment other than excepted.

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

CODES:
0 = No Entry
1 = Excepted

Variable Name	Label
	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 on 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 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 index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that 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 amount 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 adjusted.

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 will actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter 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:

Variable Name	*Label*

+9(9).99

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

SOURCE:
CWF

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

PRPAYAMT   *NCH Primary Payer Claim Paid Amount*

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

institutional, carrier, or DMERC claim.

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

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

SOURCE:
NCH

PRPAY_CD   *NCH Primary Payer Code*

The code, on an institutional claim, specifying a federal non-
Medicare program or other source that has primary

responsibility for the payment of the Medicare beneficiary's

Variable Name	*Label*

health insurance bills.

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

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

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

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

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

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

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

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

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

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

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

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

CODES:
REFER TO: BENE_PRMRY_PYR_TB
IN THE CODES APPENDIX

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

SOURCE:
NCH

Variable Name	*Label*

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

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

Variable Name	*Label*

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

certify and recertify the medical necessity of
the services rendered and/or who has primary
responsibility for the beneficiary's medical
care and treatment (attending physician).

This field is ENCRYPTED for the Limited Data Set
Standard View of the Inpatient/SNF 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 contained
10 positions (6-position UPIN and 4-position
physician surname).

SOURCE:
CWF

OP_UPIN   *Claim Operating Physician UPIN Number*

Variable Name	*Label*

On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal

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 Inpatient/SNF 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 claim.

This field is ENCRYPTED for the Limited Data Set Standard View of the Inpatient/SNF files.

DB2 ALIAS: OTHR_UPIN
SAS ALIAS: OT_UPIN
STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
TITLE ALIAS: OTH_PHYSN_UPIN

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

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

Variable Name	*Label*

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

SOURCE:
CWF

STUS_CD   *Patient Discharge Status Code*

The code used to identify the status of the patient as of the CLM_THRU_DT.

COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
DB2 ALIAS: PTNT_DSCHRG_STUS
SAS ALIAS: STUS_CD
STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
SYSTEM ALIAS: LTCLMST
TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:
REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

DGNS_E   *Claim Diagnosis E Code*

Effective with Version H, the ICD-9-CM code used to identify the external cause of injury,

poisoning, or other adverse affect. Redundantly

Variable Name	*Label*

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.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_TOT_CHRG_AMT

Variable Name	*Label*

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

IPDGNCNT   *Inpatient/SNF Claim Diagnosis Code Count*

The count of the number of diagnosis codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim diagnosis

trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_CLM_DGNS_CD_CNT
SAS ALIAS: IPDGNCNT
STANDARD ALIAS: IP_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

IPPRCNT   *Inpatient/SNF Claim Procedure Code Count*

The count of the number of procedure codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim procedure

trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_PRCDR_CD_CNT
SAS ALIAS: IPPRCNT
STANDARD ALIAS: IP_CLM_PRCDR_CD_CNT

EDIT-RULES:
RANGE: 0 TO 6

COMMENT:

Variable Name	*Label*

Prior to Version H this field was named:
CLM_PRCDR_CD_CNT.

SOURCE:
CWF

IPCONCNT   *Inpatient/SNF Claim Related Condition Code Count*

The count of the number of condition codes reported on an
inpatient/SNF claim. The purpose of this count is to indicate how
many condition code trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_RLT_COND_CD_CNT
SAS ALIAS: IPCONCNT
STANDARD ALIAS: IP_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

IPOCRCNT   *Inpatient/SNF Claim Related Occurrence Code Count*

The count of the number of occurrence codes reported on an
inpatient/SNF claim. The purpose of this count is to indicate how
many occurrence code trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_OCRNC_CD_CNT
SAS ALIAS: IPOCRCNT
STANDARD ALIAS: IP_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

IPVALCNT   *Inpatient/SNF Claim Value Code Count*

The count of the number of value codes reported on an
inpatient/SNF claim. The purpose of the count is to indicate how
many value code trailers are

present.

Variable Name	Label

2 DIGITS UNSIGNED

DB2 ALIAS: IP_VAL_CD_CNT
SAS ALIAS: IPVALCNT
STANDARD ALIAS: IP_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

IPREVCNT — Inpatient/SNF Revenue Center Code Count

The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how

many revenue center trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_REV_CNTR_CD_CNT
SAS ALIAS: IPREVCNT
STANDARD ALIAS: IP_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, 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

ADMSN_DT — Claim Admission Date

On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing

facility, or christian science sanitorium.

Variable Name	Label

For the Limited Data Set Standard View of the Inpatient/SNF files, the admission date for the claim is coded as the quarter of the calendar year when the admission occurred.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_ADMSN_DT
SAS ALIAS: ADMSN_DT
STANDARD ALIAS: CLM_ADMSN_DT
TITLE ALIAS: ADMISSION_DT

EDIT-RULES FOR LIMITED DATA SET 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

SRC_ADMS   *Claim Source Inpatient Admission Code*

The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of

(1) emergency, (2) urgent, or (3) elective.

DB2 ALIAS: SRC_IP_ADMSN_CD
SAS ALIAS: SRC_ADMS
STANDARD ALIAS: CLM_SRC_IP_ADMSN_CD
TITLE ALIAS: IP_ADMISSION_SOURCE

CODES:
REFER TO: CLM_SRC_IP_ADMSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

AD_DGNS   *Claim Admitting Diagnosis Code*

An ICD-9-CM code on the institutional inpatient/ SNF claim indicating the beneficiary's initial diagnosis at admission.

DB2 ALIAS: CLM_ADMTG_DGNS_CD
SAS ALIAS: AD_DGNS
STANDARD ALIAS: CLM_ADMTG_DGNS_CD
TITLE ALIAS: ADMITTING_DIAGNOSIS

SOURCE:

Variable Name	Label
	CWF

PTNTSTUS   *NCH Patient Status Indicator Code*

Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged,

or still a patient (used for internal CWFMQA editing purposes.)

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

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

DERIVATION:
DERIVED FROM:
NCH PTNT_DSCHRG_STUS_CD

DERIVATION RULES:

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

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

SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '30'

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

SOURCE:
NCH QA Process

PER_DIEM   *Claim Pass Thru Per Diem Amount*

f the established reimbursable costs for the current year divided by the estimated Medicare days for the current year (all PPS

claims), as calculated by the FI and reim-
bursement staff. Items reimbursed as a pass
through include capital-related costs; direct
medical education costs; kidney acquisition
costs for hospitals approved as RTCs; and
bad debts (per Provider Reimbursement Manual,

Variable Name	*Label*

Part 1, Section 2405.2). **Note: Pass throughs
are not included in the Claim Payment Amount.

9.2 DIGITS SIGNED

DB2 ALIAS: PASS_THRU_PER_DIEM
SAS ALIAS: PER_DIEM
STANDARD ALIAS: CLM_PASS_THRU_PER_DIEM_AMT
TITLE ALIAS: PER_DIEM

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the field size was:
S9(5)V99.

SOURCE:
CWF

COIN_AMT	*NCH Beneficiary Part A Coinsurance Liability Amount*

The amount of money for which the intermediary has determined
that the beneficiary is liable for Part A coinsurance on the

9.2 DIGITS SIGNED

DB2 ALIAS: PTA_COINSRNC_AMT
SAS ALIAS: COIN_AMT
STANDARD ALIAS: NCH_BENE_PTA_COINSRNC_AMT
TITLE ALIAS: BENE_PTA_COINSURANCE

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
8, 9, 10 or 11 move the corresponding value
amount to the NCH_BENE_IP_PTA_COINSRC_AMT.

COMMENT:
Prior to Version H this field was named:
BENE_PTA_COINSRNC_LBLTY_AMT and the field size
was S9(5)V99.

SOURCE:
NCH

Variable Name	*Label*

BLDDEDAM   *NCH Beneficiary Blood Deductible Liability Amount*

The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD_DDCTBL_AMT
SAS ALIAS: BLDDEDAM
STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT
TITLE ALIAS: BLOOD_DEDUCTIBLE

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
'06' move the corresponding value amount to
NCH_BENE_BLOOD_DDCTBL_AMT.

COMMENT:
Prior to Version H, this field was named:
BENE_BLOOD_DDCTBL_LBLTY_AMT and the field
size was S9(5)V99. Also, for OP claims, this
field was stored in a blood trailer. Version
H eliminated the OP blood trailer.

SOURCE:
NCH QA PROCESS

BLDTCHRG   *NCH Blood Total Charge Amount*

Effective with Version H, the total charge for blood usage (for internal CWFMQA editing purposes).

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

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD_TOT_CHRG_AMT
SAS ALIAS: BLDTCHRG
STANDARD ALIAS: NCH_BLOOD_TOT_CHRG_AMT
TITLE ALIAS: BLOOD_CHARGES

EDIT-RULES:
+9(9).99

Variable Name	Label

DERIVATION:
DERIVED FROM:
REV_CNTR_CD
REV_CNTR_TOT_CHRG_AMT

DERIVATION RULES:
Based on the presence of revenue center codes
0380 thru 0389 move the related total charge
amount to the NCH_BLOOD_TOT_CHRG_AMT.

SOURCE:
NCH QA Process

BLDNCHRG   *NCH Blood Non-Covered Charge Amount*

Effective with Version H, the total noncovered charges for blood
usage (for internal CWFMQA editing purposes).

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

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD_NCVR_AMT
DB2 ALIAS: BLOOD_NCVR_AMT
SAS ALIAS: BLDNCHRG
STANDARD ALIAS: NCH_BLOOD_NCOV_CHRG_AMT
TITLE ALIAS: BLOOD_NCV_CHARGES

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
REV_CNTR_CD
REV_CNTR_NCOV_CHRG_AMT

DERIVATION RULES:
Based on the presence of revenue center codes equal
to 0380 thru 0389 move the related noncovered
charges to NCH_BLOOD_NCOV_CHRG_AMT.

SOURCE:
NCH QA Process

PCCHGAMT   *NCH Professional Component Charge Amount*

Effective with Version H, for inpatient and out- patient claims, the
amount of physician and other professional charges covered
under Medicare Part B

(used for internal CWFMQA editing purposes and other
internal processes (e.g. if computing interim payment

Variable Name	*Label*

these charges are deducted)).

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

9.2 DIGITS SIGNED

DB2 ALIAS: PROFNL_CMPNT_AMT
SAS ALIAS: PCCHGAMT
STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT
TITLE ALIAS: PROFNL_CMPNT_CHARGES

EDIT-RULES:
+9(9).99

DERIVATION:

1. IF INPATIENT - DERIVED FROM:
CLM_VAL_CD
Clm_VAL_AMT

DERIVATION RULES:
Based on the presence of value code 04 or 05 move the related value amount to the NCH_PROFNL_CMPNT_CHRG_AMT.

2. IF OUTPATIENT - DERIVED FROM:
REV_CNTR_CD
REV_CNTR_TOT_CHRG_AMT

DERIVATION RULES (Effective 10/98):
Based on the presence of revenue center codes 096X, 097X & 098X move the related total charge amount to NCH_PROFNL_CMPNT_CHRG_AMT.

NOTE1: During the Version H conversion, this field was populated with data throughout history BUT the derivation rule applied to the outpatient claim was incomplete (i.e., revenue codes 0972, 0973, 0974 and 0979 were omitted from the calcu-lation).

SOURCE:
NCH QA Process

TDEDAMT *NCH Inpatient Total Deduction Amount*

Effective with Version H, the total Part A deductions reported on the Inpatient claim (used for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back

to 1991), but the derivation rule applied was in-
complete for claims processed prior to 10/93.
Disregard any data present in this field on claims
with NCH weekly process date earlier than 10/93.

9.2 DIGITS SIGNED

DB2 ALIAS: IP_TOT_DDCTN_AMT
SAS ALIAS: TDEDAMT
STANDARD ALIAS: NCH_BENE_IP_DDCTBL_AMT
TITLE ALIAS: IP_TOT_DEDUCTIONS

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES (Effective 10/93):
Accumulate the value amounts associated with
value codes equal to 06, 08 thru 11 and A1, B1
or C1 and move to NCH_BENE_IP_DDCTBL_AMT.
NOTE: Value codes 08-11 did not exist in the
NCH prior to 2/93; values codes A1, B1, C1 did
not exist prior to 10/93.

SOURCE:
NCH QA Process

PPS_CPTL *Claim Total PPS Capital Amount*

The total amount that is payable for capital PPS for the claim. This
is the sum of the capital hospital specific portion, federal

specific portion, outlier portion,
disproportionate share portion, indirect
medical education portion, exception payments,
and hold harmless payments.

9.2 DIGITS SIGNED

DB2 ALIAS: TOT_PPS_CPTL_AMT
SAS ALIAS: PPS_CPTL
STANDARD ALIAS: CLM_TOT_PPS_CPTL_AMT
TITLE ALIAS: PPS_CAPITAL

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:

Variable Name	*Label*

S9(7)V99.

SOURCE:
CWF

CPTL_HSP   *Claim PPS Capital HSP Amount*

Effective 3/2/92, the hospital specific portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_CPTL_HSP_AMT
SAS ALIAS: CPTL_HSP
STANDARD ALIAS: CLM_PPS_CPTL_HSP_AMT
TITLE ALIAS: PPS_CAPITAL_HSP

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

CPTL_FSP   *Claim PPS Capital FSP Amount*

Effective 3/2/92, the amount of the federal specific portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_CPTL_FSP_AMT
SAS ALIAS: CPTL_FSP
STANDARD ALIAS: CLM_PPS_CPTL_FSP_AMT
TITLE ALIAS: PPS_CAPITAL_FSP

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

CPTLOUTL   *Claim PPS Capital Outlier Amount*

Effective 3/2/92, the amount of the outlier portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_OUTLIER_AMT
SAS ALIAS: CPTLOUTL

Variable Name	*Label*

STANDARD ALIAS: CLM_PPS_CPTL_OUTLIER_AMT
TITLE ALIAS: PPS_CPTL_OUTLIER

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

DISP_SHR   *Claim PPS Capital Disproportionate Share Amount*

Effective 3/2/92, the amount of disproportionate share (rate
reflecting indigent population served) portion of the PPS payment

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_DSPRPRTNT_AMT
SAS ALIAS: DISP_SHR
STANDARD ALIAS: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT
TITLE ALIAS: PPS_DISP_SHR

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

IME_AMT   *Claim PPS Capital IME Amount*

Effective 3/2/92, the amount of the indirect medical education (IME)
 (reimbursable amount for teaching hospitals only; an added
amount passed by Congress

to augment normal PPS payments for teaching

hospitals to compensate them for higher patient

costs resulting from medical education programs for

interns and residents) portion of the PPS payment

for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_CPTL_IME_AMT
SAS ALIAS: IME_AMT
STANDARD ALIAS: CLM_PPS_CPTL_IME_AMT
TITLE ALIAS: PPS_CPTL_IME

EDIT-RULES:

Variable Name	Label

+9(9).99

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

SOURCE:
CWF

CPTL_EXP — *Claim PPS Capital Exception Amount*

Effective 3/2/92, the capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital

obligations. Exception payments expire at the

end of the 10-year transition period.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_EXCPTN_AMT
SAS ALIAS: CPTL_EXP
STANDARD ALIAS: CLM_PPS_CPTL_EXCPTN_AMT
TITLE ALIAS: PPS_CPTL_EXCP

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

HLDHRMLS — *Claim PPS Old Capital Hold Harmless Amount*

Effective 3/2/92, this amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'. The hold

harmless amount-old capital is 100 percent of the

reasonable costs of old capital for sole community

sole community hospitals, or 85 percent of

the reasonable costs associated with old capital for

all other hospitals, plus a payment for new capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_CPTL_HRMLS_AMT
SAS ALIAS: HLDHRMLS
STANDARD ALIAS: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT
TITLE ALIAS: PPS_CPTL_HOLD_HRMLS

EDIT-RULES:
+9(9).99

Variable Name	*Label*

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

SOURCE:
CWF

DSCHFRCT   *Claim PPS Capital Discharge Fraction Percent*

Effective 3/2/92, the percent resulting from dividing the days by the average length of stay for capital PPS transfer cases (PRICER

codes 03, 05, 06) not to exceed 1.

1.4 DIGITS SIGNED

DB2 ALIAS: PPS_DSCHRG_PCT
SAS ALIAS: DSCHFRCT
STANDARD ALIAS: CLM_PPS_CPTL_DSCHRG_FRCTN_PCT
TITLE ALIAS: PPS_CAPITL_DSCHRG_FRACTION_PCT

EDIT-RULES:
+9.9(4)

SOURCE:
CWF

DRGWTAMT   *Claim PPS Capital DRG Weight Number*

Effective 3/2/92, the number used to determine a transfer adjusted case mix index for capital PPS. The number is determined by multiplying

the DRG weight times the discharge fraction.

3.4 DIGITS SIGNED

DB2 ALIAS: PPS_DRG_WT_NUM
SAS ALIAS: DRGWTAMT
STANDARD ALIAS: CLM_PPS_CPTL_DRG_WT_NUM
TITLE ALIAS: PPS_CAPITAL_DRG_WEIGHT_NUM

EDIT-RULES:
+999.9(4)

SOURCE:
CWF

UTIL_DAY   *Claim Utilization Day Count*

On an institutional claim, the number of covered days of care that are chargeable

to Medicare facility utilization that
includes full days, coinsurance days, and
lifetime reserve days.

3 DIGITS SIGNED

Variable Name	Label

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

EDIT-RULES:
+999

SOURCE:
CWF

COIN_DAY — Beneficiary Total Coinsurance Days Count

The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.

3 DIGITS SIGNED

DB2 ALIAS: COINSRNC_DAY_CNT
SAS ALIAS: COIN_DAY
STANDARD ALIAS: BENE_TOT_COINSRNC_DAY_CNT
TITLE ALIAS: COINSRNC_DAYS

EDIT-RULES:
+999

SOURCE:
CWF

LRD_USE — Beneficiary LRD Used Count

The number of lifetime reserve days that the beneficiary has elected to use during the period

covered by the institutional claim. Under Medicare,
each beneficiary has a one-time reserve of sixty
additional days of inpatient hospital coverage
that can be used after 90 days of inpatient care
have been provided in a single benefit period.
This count is used to subtract from the total
number of lifetime reserve days that a beneficiary
has available.

3 DIGITS SIGNED

DB2 ALIAS: BENE_LRD_USE_CNT
SAS ALIAS: LRD_USE
STANDARD ALIAS: BENE_LRD_USE_CNT
TITLE ALIAS: LRD_USED

EDIT-RULES:
+999

SOURCE:
CWF

Variable Name	*Label*

NUTILDAY

Claim Non Utilization Days Count

On an institutional claim, the number of days of care that are not chargeable to Medicare facility utilization.

5 DIGITS SIGNED

DB2 ALIAS: NUTLZTN_DAY_CNT
SAS ALIAS: NUTILDAY
STANDARD ALIAS: CLM_NUTLZTN_DAY_CNT
TITLE ALIAS: NUTLZTN_DAYS

EDIT-RULES:
+9(5)

SOURCE:
CWF

BLDFRNSH

NCH Blood Pints Furnished Quantity

Number of whole pints of blood furnished to the beneficiary.
3 DIGITS SIGNED

DB2 ALIAS: NCH_BLOOD_PT_FRNSH
SAS ALIAS: BLDFRNSH
STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY
TITLE ALIAS: BLOOD_PINTS_FURNISHED

EDIT-RULES:
+999

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
37 move the related value amount to the
NCH_BLOOD_PT_FRNSH_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_PT_FRNSH_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

SOURCE:
NCH QA Process

BLD_RPLC

NCH Blood Pints Replaced Quantity

Variable Name	*Label*

Number of whole pints of blood replaced. 3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_RPLC_QTY
SAS ALIAS: BLD_RPLC
STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY
TITLE ALIAS: BLOOD_PINTS_REPLACED

EDIT-RULES:
+999

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
39 move the related value amount to the
NCH_BLOOD_PT_RPLC_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_PT_RPLC_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

SOURCE:
NCH QA Process

BLDNRPLC   *NCH Blood Pints Not Replaced Quantity*

Number of whole pints of blood not replaced. 3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_NRPLC_QTY
SAS ALIAS: BLDNRPLC
STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY
TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED

EDIT-RULES:
+999

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Subtract value code 39 amount from value code
37 amount and move the result to
NCH_BLOOD_PT_NRPLC_QTY.

COMMENT:

Variable Name	*Label*

Prior to Version H this field was named:
CLM_BLOOD_PT_NRPLC_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

SOURCE:
NCH QA Process

BLDDEDPT   *NCH Blood Deductible Pints Quantity*

The quantity of blood pints applied (blood deductible).
3 DIGITS SIGNED

DB2 ALIAS: BLOOD_DDCTBL_QTY
SAS ALIAS: BLDDEDPT
STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY
TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE

EDIT-RULES:
+999

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
38 move the related value amount to the
NCH_BLOOD_DDCTBL_PT_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_DDCTBL_PT_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

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

Variable Name	*Label*

three days in a row if the source of admission is other than 'A'.

For the Limited Data Set Standard View of the Inpatient/SNF files, the beneficiary's qualifying stay through date is coded as the quarter of calendar year when the stay through date 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: QLFY_STAY_THRU_DT
SAS ALIAS: QLFYTHRU
STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT
TITLE ALIAS: QLFYG_STAY_THRU_DT

EDIT-RULES FOR LIMITED DATA SET 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 Inpatient/SNF files, the beneficiary's discharge date is coded as the quarter of the calendar year when the discharge

Variable Name	*Label*

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

DERIVATION:
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

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

SOURCE:
NCH QA Process

DRG_CD   *Claim Diagnosis Related Group Code*

The diagnostic related group to which a hospital claim belongs for
 prospective payment purposes.
COMMON ALIAS: DRG
DB2 ALIAS: CLM_DRG_CD
SAS ALIAS: DRG_CD
STANDARD ALIAS: CLM_DRG_CD
TITLE ALIAS: DRG

EDIT-RULES:
DRG DEFINITIONS MANUAL

COMMENT:
GROUPER is the software that determines the DRG
from data elements reported by the hospital.
Once determined, the DRG code is one of the
elements used to determine the price upon which

Variable Name	Label

to base the reimbursement to the hospitals
under prospective payment. Nonpayment claims
(zero reimbursement) may not have a DRG present.

SOURCE:
CWF

OUTLR_CD   *Claim Diagnosis Related Group Outlier Stay Code*

On an institutional claim, the code that indicates the beneficiary
stay under the prospective payment system which, although

classified into a specific diagnosis related
group, has an unusually long length (day
outlier) or exceptionally high cost
(cost outlier).

DB2 ALIAS: DRG_OUTLIER_CD
SAS ALIAS: OUTLR_CD
STANDARD ALIAS: CLM_DRG_OUTLIER_STAY_CD
TITLE ALIAS: DRG_OUTLIER_STAY_CODE

CODES:
REFER TO: DRG_OUTLIER_STAY_TB

SOURCE:
CWF

OUTLRPMT   *NCH DRG Outlier Approved Payment Amount*

On an institutional claim, the additional payment amount approved
 by the Peer Review Organization due to an outlier situation for

a beneficiary's stay under the prospective
payment system, which has been classified
into a specific diagnosis related group.

9.2 DIGITS SIGNED

DB2 ALIAS: DRG_OUTLIER_AMT
SAS ALIAS: OUTLRPMT
STANDARD ALIAS: NCH_DRG_OUTLIER_APRV_PMT_AMT
TITLE ALIAS: DRG_OUTLIER_PMT

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal
to 17 move the related amount to

Variable Name	*Label*

NCH_DRG_OUTLIER_APRV_PMT_AMT.

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

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.

PRCDRCD{x}   *Claim Procedure Code*

where { x } ranges from 1 to 6

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

DB2 ALIAS: CLM_PRCDR_CD
SAS ALIAS: PRCDR_CD
STANDARD ALIAS: CLM_PRCDR_CD
TITLE ALIAS: PROCEDURE_CODE

EDIT-RULES:
ICD-9-CM

SOURCE:

Variable Name	Label

CWF

PRCDRDT{x}   *Claim Procedure Performed Date*

where { x } ranges from 1 to 6

On an institutional claim, the date on which the principal or other procedure was performed.

For the Limited Data Set Standard View of
the Inpatient/SNF files, the claim procedure
performed date is coded as the quarter
of the calendar year when the procedure
was performed.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_PRCDR_PRFRM_DT
SAS ALIAS: PRCDR_DT
STANDARD ALIAS: CLM_PRCDR_PRFRM_DT
TITLE ALIAS: PROCEDURE_DATE

EDIT-RULES FOR LIMITED DATA SET 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

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

Variable Name	*Label*

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

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 Inpatient/SNF files, the claim procedure
performed date is coded as the quarter

Variable Name	*Label*

of the calendar year when the procedure
was performed.

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 LIMITED DATA SET 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

Variable Name	**Label**

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

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVCNTR{x}   *Revenue Center Code*

where { x } ranges from 1 to 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 accommodation or 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

Variable Name	*Label*

Inpatient/SNF, 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-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 LIMITED DATA SET DATA:
YYYYQ000 WHERE Q IS ONE OF THE
FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:
CWF

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

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 Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are

Variable Name	*Label*

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*

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.

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 pur-
poses.

The HIPPS code for Home Health PPS identifies
(1) the three case-mix dimensions of the HHRG system,
clinical, functional and utilization, from which a
beneficiary is assigned to one of the 80 HHRG
categories and (2) it identifies whether or not
the elements of the code were computed or derived.
The HHRGs, represented bythe 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

Variable Name	Label

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

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: REV_CNTR_HCPCS_INITL_MDFR_CD
TITLE ALIAS: INITIAL_MODIFIER

EDIT-RULES:
Carrier Information File

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

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.

Variable Name	Label

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

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.

Variable Name	Label

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

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

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.

Variable Name	*Label*

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 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
$1 = 1.0$
$2 = (1.0+D(U-1))/U$
$3 = T/U$
$4 = (1+D)/U$
$5 = D$
$6 = TD/U$

Variable Name	*Label*

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.   CMS 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

Variable Name	Label

associated with revenue center code '0624'.

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

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

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

SOURCE:
CWF

RVUNT{x}   Revenue Center Unit Count

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 quantitative measure (unit) of the number of times the service or
procedure being reported was performed according

to the revenue center/HCPCS code definition as described on
an institutional claim.

Depending on type of service, units are measured by number
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.

Variable Name	*Label*

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.

7 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_UNIT_CNT
SAS ALIAS: REV_UNIT
STANDARD ALIAS: REV_CNTR_UNIT_CNT
TITLE ALIAS: UNITS

EDIT-RULES:
+9(7)

SOURCE:
CWF

RVRT{x}   *Revenue Center Rate Amount*

where { x } ranges from 1 to 58

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:
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

Variable Name	*Label*

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

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

Variable Name	Label

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 the line for a

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

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVMSP1{x} *Revenue Center 1st Medicare Secondary Payer Paid*
   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 primary payer when the payer is primary to Medicare (Medicare is secondary or

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}   *Revenue Center 2nd Medicare Secondary Payer Paid*

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 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

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.

Variable Name	*Label*

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:
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

Variable Name	*Label*

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

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

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVCHRG{x}	*Revenue Center Total Charge Amount*

where { x } ranges from 1 to 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 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 been 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 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:
+9(9).99

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

SOURCE:
CWF

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

where { x } ranges from 1 to 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 and the element was only present on the Inpatient/SNF format.

Variable Name	*Label*
	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:
+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: 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