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CODEBOOK

Medicare Fee-For-Service Claims (for Version K)

December 2017

Version 1.4

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Revision History

Revision Date	Version Number	Description	Author(s)
05/01/17	1.0	Initial release of Codebook for Medicare Fee-For-Service Claims, Version K.	Kathy Schneider, Chris Alleman
05/26/17	1.1	CLM_PRCR_RTRN_CD , length corrected. PLCSRVC , Values 1-9 updated to 01-09. REV_CNTR , added Values 1000-1002, 2101, 2103, 2101, 3103, 3104, and 3109. RFR_NPI , removed; see RFR_PHYSN_NPI. RFR_PHYSN_NPI , updated Comment section. RNDRNG_PHYSN_NPI , updated Label, Description and Comment section. RNDRNG_PHYSN_SPCLTY_CD , updated Label, Long Name and Comment section. THRPY_CAP_IND_CD1 – THRPY_CAP_IND_CD5 , updated Label, Description and Comment section. VAL_CD , updated/added Values (69, 80-84, D5, FC, FD).	Kathy Schneider, Chris Alleman
06/21/17	1.2	CLM_SRVC_FAC_ZIP_CD , corrected Short SAS Name.	Chris Alleman
11/15/17	1.3	Corrected page numbering and Quick Link hyperlinks.	Chris Alleman
12/11/17	1.4	Variable sort modified to reference Long Name vs. Short Name.	Chris Alleman

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the Medicare Fee-For-Service Claims (for Version K) files. Because the files have such a large number of variables, we have included several ways for analysts to quickly find the information they need.

- A complete listing of all variables in the files, in alphabetical order based on their SAS variable names.
- Individual entries for each variable that contain a short description of the variable, the possible values for the variable, and, in many cases, notes that discuss how the variable was constructed and should be used.

We have included hyperlinks throughout the codebook to make it easier for analysts to navigate between the table of contents and the detailed entries for the individual variables:

- Clicking on any variable name in the Table of Contents will take you to the detailed description for that variable.
- From the detailed description for any individual variable, clicking on the [^Back to TOC^](#) link after each variable description will take you back to the Table of Contents.

Table of Contents

This section of the Codebook contains a list of all variables in alphabetical order based on the SAS variable name.

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Variable Details

This section of the Codebook contains one entry for each variable in the Medicare Fee-For-Service Claims (Version K) files. Each entry contains variable details to facilitate understanding and use of the variables.

ACO_ID_NUM

LABEL: Claim Accountable Care Organization (ACO) Identification Number

DESCRIPTION: The field identifies the Accountable Care Organization (ACO) Identification Number.

SHORT NAME: ACO_ID_NUM

LONG NAME: ACO_ID_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: -

COMMENT: -

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ADMTG_DGNS_CD

LABEL: Claim Admitting Diagnosis Code

DESCRIPTION: A diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission.

This diagnosis code may not be confirmed after the patient is evaluated; it may be different than the eventual diagnoses (e.g., as in PRNCPAL_DGNS_CD or ICD_DGNS_CD1-25).

SHORT NAME: ADMTG_DGNS_CD

LONG NAME: ADMTG_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: -

COMMENT: -

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ADMTG_DGNS_VRSN_CD

LABEL: Claim Admitting Diagnosis Version Code (ICD-9 or ICD-10)

DESCRIPTION: Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

SHORT NAME: ADMTG_DGNS_VRSN_CD

LONG NAME: ADMTG_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Blank = ICD-9
9 = ICD-9
0 = ICD-10

COMMENT: On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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ASGMNTCD

LABEL: Carrier Claim Provider Assignment Indicator Switch

DESCRIPTION: Variable indicates whether or not the provider accepts assignment for the non-institutional claim.

SHORT NAME: ASGMNTCD

LONG NAME: CARR_CLM_PRVDR_ASGNMT_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: A = Assigned claim
N = Non-assigned claim

COMMENT: -

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AT_PHYSN_NPI

LABEL: Claim Attending Physician NPI Number

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

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

SHORT NAME: AT_NPI

LONG NAME: AT_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: -

COMMENT: -

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AT_PHYSN_SPCLTY_CD

LABEL: Claim Attending Physician Specialty Code

DESCRIPTION: This variable is the code used to identify the CMS specialty code corresponding to the attending physician.

SHORT NAME: AT_PHYSN_SPCLTY_CD

LONG NAME: AT_PHYSN_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/03)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech / language pathology
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = General Psychiatry
- 28 = Colorectal surgery (formerly proctology)
- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation

- 32 = Anesthesiologist Assistants (eff. 4/1/03—previously grouped with Certified Registered Nurse Anesthetists (CRNA))
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometrist
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/03)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
- 47 = Independent Diagnostic Testing Facility (IDTF)
- 48 = Podiatry
- 49 = Ambulatory surgical center (formerly miscellaneous)
- 50 = Nurse practitioner
- 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
- 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 54 = Medical supply company for DMERC (and not included in 51-53)
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-orthotist
- 58 = Medical supply company with registered pharmacist
- 59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
- 60 = Public health or welfare agencies (federal, state, and local)
- 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
- 62 = Psychologist (billing independently)
- 63 = Portable X-ray supplier
- 64 = Audiologist (billing independently)
- 65 = Physical therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 66 = Rheumatology

- 67 = Occupational therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 68 = Clinical psychologist
- 69 = Clinical laboratory (billing independently)
- 70 = Multispecialty clinic or group practice
- 71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
- 72 = Pain Management (eff. 1/1/02)
- 73 = Mass Immunization Roster Biller
- 74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF))
- 75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs -- eff. 4/1/03))
- 76 = Peripheral vascular disease
- 77 = Vascular surgery
- 78 = Cardiac surgery
- 79 = Addiction medicine
- 80 = Licensed clinical social worker
- 81 = Critical care (intensivists)
- 82 = Hematology
- 83 = Hematology/oncology
- 84 = Preventive medicine
- 85 = Maxillofacial surgery
- 86 = Neuropsychiatry
- 87 = All other suppliers (e.g. drug and department stores)
- 88 = Unknown supplier/provider specialty
- 89 = Certified clinical nurse specialist
- 90 = Medical oncology
- 91 = Surgical oncology
- 92 = Radiation oncology
- 93 = Emergency medicine
- 94 = Interventional radiology
- 95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory
- 96 = Optician
- 97 = Physician assistant
- 98 = Gynecologist/oncologist
- 99 = Unknown physician specialty
- A0 = Hospital (DMERCs only)
- A1 = SNF (DMERCs only)
- A2 = Intermediate care nursing facility (DMERCs only)
- A3 = Nursing facility, other (DMERCs only)
- A4 = Home Health Agency (DMERCs only)
- A5 = Pharmacy (DMERC)
- A6 = Medical supply company with respiratory therapist (DMERCs only)

- A7 = Department store (DMERC)
- A8 = Grocery store (DMERC)
- A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities, eff. 1/2005)
- B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)
- B2 = Pedorthic Personnel (eff. 10/2/07)
- B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/07)
- B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/07)
- B5 = Ocularist
- C0 = Sleep medicine
- C1 = Centralized flu
- C2 = Indirect payment procedure
- C3 = Interventional cardiology
- C5 = Dentist (eff. 7/2016)

COMMENT: -

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AT_PHYSN_UPIN

LABEL: Claim Attending Physician UPIN Number

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

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

SHORT NAME: AT_UPIN

LONG NAME: AT_PHYSN_UPIN

TYPE: CHAR

LENGTH: 6

SOURCE: NCH

VALUES: -

COMMENT: -

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BENE_CNTY_CD

LABEL: County Code from Claim (SSA)

DESCRIPTION: The 3-digit social security administration (SSA) standard county code of a beneficiary's residence.

SHORT NAME: CNTY_CD

LONG NAME: BENE_CNTY_CD

TYPE: CHAR

LENGTH: 3

SOURCE: SSA/EDB

VALUES: -

COMMENT: A listing of county codes can be found on the US Census website; also CMS has core-based statistical area (CBSA) crosswalk files available on their website, which include state and county SSA codes.

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BENE_HOSPC_PRD_CNT

LABEL: Beneficiary's Hospice Period Count

DESCRIPTION: The count of the number of hospice period trailers present for the beneficiary's record.

Medicare covers hospice benefit periods which may consist of 2 initial 90 day periods followed by an unlimited number of 60 day periods.

Hospice benefits are generally in lieu of standard Part A hospital benefits for treating the terminal condition.

SHORT NAME: HOSPCPRD

LONG NAME: BENE_HOSPC_PRD_CNT

TYPE: NUM

LENGTH: 1

SOURCE: NCH

VALUES: -

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" (see:

http://www.medpac.gov/payment_basics.cfm).

Also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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BENE_ID

LABEL: Encrypted CCW Beneficiary ID

DESCRIPTION: The unique CCW identifier for a beneficiary.

The CCW assigns a unique beneficiary identification number to each individual who receives Medicare and/or Medicaid, and uses that number to identify an individual's records in all CCW data files (e.g., Medicare claims, MAX claims, MDS assessment data).

This number does not change during a beneficiary's lifetime and each number is used only once.

The BENE_ID is specific to the CCW and is not applicable to any other identification system or data source.

SHORT NAME: BENE_ID

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

VALUES: -

COMMENT: -

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BENE_LRD_USED_CNT

LABEL: Beneficiary Medicare Lifetime Reserve Days (LRD) Used Count

DESCRIPTION: 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.

SHORT NAME: LRD_USE

LONG NAME: BENE_LRD_USED_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: -

COMMENT: -

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BENE_MLG_CNTCT_ZIP_CD

LABEL: ZIP Code of Residence from Claim

DESCRIPTION: The ZIP code of the mailing address where the beneficiary may be contacted.

SHORT NAME: ZIP_CD

LONG NAME: BENE_MLG_CNTCT_ZIP_CD

TYPE: CHAR

LENGTH: 9

SOURCE: EDB

VALUES: -

COMMENT: -

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BENE_RACE_CD

LABEL: Beneficiary Race Code

DESCRIPTION: Race code from claim

SHORT NAME: RACE_CD

LONG NAME: BENE_RACE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: SSA

VALUES:

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

COMMENT: -

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BENE_STATE_CD

LABEL: Beneficiary Residence (SSA) State Code

DESCRIPTION: The social security administration (SSA) standard 2-digit state code of a beneficiary's residence.

SHORT NAME: STATE_CD

LONG NAME: BENE_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: SSA/EDB

VALUES:

- 01 = Alabama
- 02 = Alaska
- 03 = Arizona
- 04 = Arkansas
- 05 = California
- 06 = Colorado
- 07 = Connecticut
- 08 = Delaware
- 09 = District of Columbia
- 10 = Florida
- 11 = Georgia
- 12 = Hawaii
- 13 = Idaho
- 14 = Illinois
- 15 = Indiana
- 16 = Iowa
- 17 = Kansas
- 18 = Kentucky
- 19 = Louisiana
- 20 = Maine
- 21 = Maryland
- 22 = Massachusetts
- 23 = Michigan
- 24 = Minnesota
- 25 = Mississippi
- 26 = Missouri
- 27 = Montana
- 28 = Nebraska
- 29 = Nevada
- 30 = New Hampshire
- 31 = New Jersey

32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = California
56 = Canada & Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
66 = Commonwealth of the Northern Marianas Islands
67 = Texas
68 = Florida (eff. 10/2005)
69 = Florida (eff. 10/2005)
70 = Kansas (eff. 10/2005)
71 = Louisiana (eff. 10/2005)
72 = Ohio (eff. 10/2005)
73 = Pennsylvania (eff. 10/2005)
74 = Texas (eff. 10/2005)
80 = Maryland (eff. 8/2000)

97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa;
otherwise unknown

COMMENT: -

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BENE_TOT_COINSRNC_DAYS_CNT

LABEL: Beneficiary Total Coinsurance Days Count

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

During each benefit period (calendar year) the beneficiary is responsible for coinsurance for particular days of inpatient care (no coinsurance from day 1 through day 60, then for days 61 through 90 there is 25% coinsurance), SNF care (no coinsurance until day 21, then is 1/8 of inpatient hospital deductible amount through 100th day of SNF).

Different rules apply for lifetime reserve days, etc.

SHORT NAME: COIN_DAY

LONG NAME: BENE_TOT_COINSRNC_DAYS_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: -

COMMENT: -

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BETOS_CD

LABEL: Line Berenson-Eggers Type of Service (BETOS) Code

DESCRIPTION: The Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services.

This field is included as a line item on the non-institutional claim.

SHORT NAME: BETOS

LONG NAME: BETOS_CD

TYPE: CHAR

LENGTH: 3

SOURCE: NCH

VALUES:

- M1A = Office visits - new
- M1B = Office visits - established
- M2A = Hospital visit - initial
- M2B = Hospital visit - subsequent
- M2C = Hospital visit - critical care
- M3 = Emergency room visit
- M4A = Home visit
- M4B = Nursing home visit
- M5A = Specialist - pathology
- M5B = Specialist - psychiatry
- M5C = Specialist - ophthalmology
- M5D = Specialist - other
- M6 = Consultations
- P0 = Anesthesia
- P1A = Major procedure - breast
- P1B = Major procedure - colectomy
- P1C = Major procedure - cholecystectomy
- P1D = Major procedure - turp
- P1E = Major procedure - hysterectomy
- P1F = Major procedure - explor/decompr/excisdisc
- P1G = Major procedure - Other
- P2A = Major procedure, cardiovascular-CABG
- P2B = Major procedure, cardiovascular-Aneurysm repair
- P2C = Major Procedure, cardiovascular-Thromboendarterectomy
- P2D = Major procedure, cardiovascular-Coronary angioplasty (PTCA)
- P2E = Major procedure, cardiovascular-Pacemaker insertion
- P2F = Major procedure, cardiovascular-Other
- P3A = Major procedure, orthopedic - Hip fracture repair
- P3B = Major procedure, orthopedic - Hip replacement

P3C = Major procedure, orthopedic - Knee replacement
 P3D = Major procedure, orthopedic - other
 P4A = Eye procedure - corneal transplant
 P4B = Eye procedure - cataract removal/lens insertion
 P4C = Eye procedure - retinal detachment
 P4D = Eye procedure - treatment of retinal lesions
 P4E = Eye procedure - other
 P5A = Ambulatory procedures - skin
 P5B = Ambulatory procedures - musculoskeletal
 P5C = Ambulatory procedures - inguinal hernia repair
 P5D = Ambulatory procedures - lithotripsy
 P5E = Ambulatory procedures - other
 P6A = Minor procedures - skin
 P6B = Minor procedures - musculoskeletal
 P6C = Minor procedures - other (Medicare fee schedule)
 P6D = Minor procedures - other (non-Medicare fee schedule)
 P7A = Oncology - radiation therapy
 P7B = Oncology - other
 P8A = Endoscopy - arthroscopy
 P8B = Endoscopy - upper gastrointestinal
 P8C = Endoscopy - sigmoidoscopy
 P8D = Endoscopy - colonoscopy
 P8E = Endoscopy - cystoscopy
 P8F = Endoscopy - bronchoscopy
 P8G = Endoscopy - laparoscopic cholecystectomy
 P8H = Endoscopy - laryngoscopy
 P8I = Endoscopy - other
 P9A = Dialysis services (Medicare fee schedule)
 P9B = Dialysis services (non-Medicare fee schedule)
 I1A = Standard imaging - chest
 I1B = Standard imaging - musculoskeletal
 I1C = Standard imaging - breast
 I1D = Standard imaging - contrast gastrointestinal
 I1E = Standard imaging - nuclear medicine
 I1F = Standard imaging - other
 I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck
 I2B = Advanced imaging - CAT/CT/CTA: other
 I2C = Advanced imaging - MRI/MRA: brain/head/neck
 I2D = Advanced imaging - MRI/MRA: other
 I3A = Echography/ultrasonography - eye
 I3B = Echography/ultrasonography - abdomen/pelvis
 I3C = Echography/ultrasonography - heart
 I3D = Echography/ultrasonography - carotid arteries
 I3E = Echography/ultrasonography - prostate, transrectal

I3F = Echography/ultrasonography - other
 I4A = Imaging/procedure - heart including cardiac catheterization
 I4B = Imaging/procedure - other
 T1A = Lab tests - routine venipuncture (non-Medicare fee schedule)
 T1B = Lab tests - automated general profiles
 T1C = Lab tests - urinalysis
 T1D = Lab tests - blood counts
 T1E = Lab tests - glucose
 T1F = Lab tests - bacterial cultures
 T1G = Lab tests - other (Medicare fee schedule)
 T1H = Lab tests - other (non-Medicare fee schedule)
 T2A = Other tests - electrocardiograms
 T2B = Other tests - cardiovascular stress tests
 T2C = Other tests - EKG monitoring
 T2D = Other tests - other
 D1A = Medical/surgical supplies
 D1B = Hospital beds
 D1C = Oxygen and supplies
 D1D = Wheelchairs
 D1E = Other DME
 D1F = Prosthetic/Orthotic devices
 D1G = Drugs Administered through DME
 O1A = Ambulance
 O1B = Chiropractic
 O1C = Enteral and parenteral
 O1D = Chemotherapy
 O1E = Other drugs
 O1F = Hearing and speech services
 O1G = Immunizations/Vaccinations
 Y1 = Other - Medicare fee schedule
 Y2 = Other - non-Medicare fee schedule
 Z1 = Local codes
 Z2 = Undefined codes

COMMENT: -

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CARR_CLM_BLG_NPI_NUM

LABEL: Carrier Claim Billing NPI Number

DESCRIPTION: The CMS National Provider Identifier (NPI) number assigned to the billing provider

SHORT NAME: CARR_CLM_BLG_NPI_NUM

LONG NAME: CARR_CLM_BLG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: -

COMMENT: -

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CARR_CLM_CASH_DDCTBL_APLD_AMT

LABEL: Carrier Claim Cash Deductible Applied Amount (sum of all line-level deductible amounts)

DESCRIPTION: The amount of the cash deductible as submitted on the claim.

This variable is the beneficiary's liability under the annual Part B deductible for all line items on the claim; it is the sum of all line-level deductible amounts. (variable called LINE_BENE_PTB_DDCTBL_AMT)

The Part B deductible applies to both institutional (e.g., HOP) and non-institutional (e.g., Carrier and DME) services.

SHORT NAME: DEDAPPLY

LONG NAME: CARR_CLM_CASH_DDCTBL_APLD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles.

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CARR_CLM_ENTRY_CD

LABEL: Carrier Claim Entry Code

DESCRIPTION: Carrier-generated code describing whether the Part B claim is an original debit, full credit, or replacement debit.

SHORT NAME: ENTRY_CD

LONG NAME: CARR_CLM_ENTRY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

1 =	Original debit; void of original debit (If CLM_DISP_CD = 3, code 1 means voided original debit)
3 =	Full credit
5 =	Replacement debit
9 =	Accrete bill history only

COMMENT: -

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CARR_CLM_HCPCS_YR_CD

LABEL: Claim Healthcare Common Procedure Coding System (HCPCS) Year Code

DESCRIPTION: The terminal digit of the Healthcare Common Procedure Coding System (HCPCS) version used to code the claim.

SHORT NAME: HCPCS_YR

LONG NAME: CARR_CLM_HCPCS_YR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = 2011
2 = 2012
3 = 2013
4 = 2014
etc.

COMMENT: -

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CARR_CLM_PMT_DNL_CD

LABEL:	Carrier Claim Payment Denial Code																																																																														
DESCRIPTION:	The code on a non-institutional claim indicating to whom payment was made or if the claim was denied.																																																																														
SHORT NAME:	PMTDNLCD																																																																														
LONG NAME:	CARR_CLM_PMT_DNL_CD																																																																														
TYPE:	CHAR																																																																														
LENGTH:	2																																																																														
SOURCE:	NCH																																																																														
VALUES:	<p>Only one-byte was used until 1/2011 (currently, either 1 or 2-byte values may be used, symbols not currently allowed)</p> <table><tr><td>0</td><td>=</td><td>Denied</td></tr><tr><td>1</td><td>=</td><td>Physician/supplier</td></tr><tr><td>2</td><td>=</td><td>Beneficiary</td></tr><tr><td>3</td><td>=</td><td>Both physician/supplier and beneficiary</td></tr><tr><td>4</td><td>=</td><td>Hospital (hospital based physicians)</td></tr><tr><td>5</td><td>=</td><td>Both hospital and beneficiary</td></tr><tr><td>6</td><td>=</td><td>Group practice prepayment plan</td></tr><tr><td>7</td><td>=</td><td>Other entries (e.g. Employer, union)</td></tr><tr><td>8</td><td>=</td><td>Federally funded</td></tr><tr><td>9</td><td>=</td><td>PA service</td></tr><tr><td>A</td><td>=</td><td>Beneficiary under limitation of liability</td></tr><tr><td>B</td><td>=</td><td>Physician/supplier under limitation of liability</td></tr><tr><td>D</td><td>=</td><td>Denied due to demonstration involvement</td></tr><tr><td>E</td><td>=</td><td>MSP cost avoided IRS/SSA/HCFA Data Match (after 01/2001 is First Claim Development)</td></tr><tr><td>F</td><td>=</td><td>MSP cost avoided HMO Rate Cell (after 1/2001 is Trauma Code Development)</td></tr><tr><td>G</td><td>=</td><td>MSP cost avoided Litigation Settlement (after 1/2001 is Secondary Claims Investigation)</td></tr><tr><td>H</td><td>=</td><td>MSP cost avoided Employer Voluntary Reporting (after 1/2001 is Self-Reports)</td></tr><tr><td>J</td><td>=</td><td>MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)</td></tr><tr><td>K</td><td>=</td><td>MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)</td></tr><tr><td>P</td><td>=</td><td>Physician ownership denial</td></tr><tr><td>Q</td><td>=</td><td>MSP cost avoided - voluntary agreements including with employer</td></tr><tr><td>T</td><td>=</td><td>MSP cost avoided - Initial Enrollment Questionnaire</td></tr><tr><td>U</td><td>=</td><td>MSP cost avoided - HMO rate cell adjustment</td></tr><tr><td>V</td><td>=</td><td>MSP cost avoided - litigation settlement</td></tr><tr><td>X</td><td>=</td><td>MSP cost avoided – generic</td></tr><tr><td>Y</td><td>=</td><td>MSP cost avoided - IRS/SSA data match</td></tr></table>	0	=	Denied	1	=	Physician/supplier	2	=	Beneficiary	3	=	Both physician/supplier and beneficiary	4	=	Hospital (hospital based physicians)	5	=	Both hospital and beneficiary	6	=	Group practice prepayment plan	7	=	Other entries (e.g. Employer, union)	8	=	Federally funded	9	=	PA service	A	=	Beneficiary under limitation of liability	B	=	Physician/supplier under limitation of liability	D	=	Denied due to demonstration involvement	E	=	MSP cost avoided IRS/SSA/HCFA Data Match (after 01/2001 is First Claim Development)	F	=	MSP cost avoided HMO Rate Cell (after 1/2001 is Trauma Code Development)	G	=	MSP cost avoided Litigation Settlement (after 1/2001 is Secondary Claims Investigation)	H	=	MSP cost avoided Employer Voluntary Reporting (after 1/2001 is Self-Reports)	J	=	MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)	K	=	MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)	P	=	Physician ownership denial	Q	=	MSP cost avoided - voluntary agreements including with employer	T	=	MSP cost avoided - Initial Enrollment Questionnaire	U	=	MSP cost avoided - HMO rate cell adjustment	V	=	MSP cost avoided - litigation settlement	X	=	MSP cost avoided – generic	Y	=	MSP cost avoided - IRS/SSA data match
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Q	=	MSP cost avoided - voluntary agreements including with employer																																																																													
T	=	MSP cost avoided - Initial Enrollment Questionnaire																																																																													
U	=	MSP cost avoided - HMO rate cell adjustment																																																																													
V	=	MSP cost avoided - litigation settlement																																																																													
X	=	MSP cost avoided – generic																																																																													
Y	=	MSP cost avoided - IRS/SSA data match																																																																													

- 00 = MSP cost avoided - COB Contractor
- 12 = MSP cost avoided - BC/BS Voluntary Data Sharing Agreements (VDSA)
- 13 = MSP cost avoided - Office of Personnel Management (OPM) Data Match
- 14 = MSP cost avoided - Workman's Compensation (WC) Data Match
- 15 = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA)
- 16 = MSP cost avoided - Liability Insurer VDSA
- 17 = MSP cost avoided - No-Fault Insurer VDSA
- 18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement
- 21 = MSP cost avoided - MIR Group Health Plan
- 22 = MSP cost avoided - MIR non-Group Health Plan
- 25 = MSP cost avoided - Recovery Audit Contractor – California
- 26 = MSP cost avoided - Recovery Audit Contractor – Florida
- 41 = MSP cost avoided - non-Group Health Plan non-Ongoing responsibility for medical (ORM)
- 43 = MSP cost avoided - Medicare Part C/Medicare Advantage

Prior to 2011, the following 1-byte character codes were also valid (these characters preceded use of 2-byte codes, above):

- ! = MSP cost avoided - COB Contractor (converted to '00' 2-byte code)
- @ = MSP cost avoided - BC/BS Voluntary Agreements (converted to '12' 2-byte code)
- # = MSP cost avoided - Office of Personnel Management (converted to '13' 2-byte code)
- \$ = MSP cost avoided - Workman's Compensation (WC) Datamatch (converted to '14' 2-byte code)
- * = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006) (converted to '15' 2-byte code)
- (= MSP cost avoided - Liability Insurer VDSA (eff. 4/2006) (converted to '16' 2-byte code)
-) = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006) (converted to '17' 2-byte code)
- + = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006) (converted to '18' 2-byte code)
- < = MSP cost avoided - MIR Group Health Plan (eff. 1/2009) (converted to '21' 2-byte code)
- > = MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009) (converted to '22' 2-byte code)
- % = MSP cost avoided - Recovery Audit Contractor - California (eff. 10/2005) (converted to '25' 2-byte code)
- & = MSP cost avoided - Recovery Audit Contractor - Florida (eff. 10/2005) (converted to '26' 2-byte code)

COMMENT: Effective with Version 'J', the field was expanded on the NCH record to 2 bytes, With his expansion, the NCH will no longer use the character values to represent the official two

byte values sent in by NCH since 4/2002. During the Version J conversion, all character values were converted to the two byte values.

On 4/1/02, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value.

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CARR_CLM_RFRNG_PIN_NUM

LABEL:	Carrier Claim Referring Provider ID Number (PIN)
DESCRIPTION:	The provider identification number (PIN) of the physician/supplier (assigned by the MAC) who referred the beneficiary to the physician who ordered these services.
SHORT NAME:	RFR_PRFL
LONG NAME:	CARR_CLM_RFRNG_PIN_NUM
TYPE:	CHAR
LENGTH:	14
SOURCE:	NCH
VALUES:	-
COMMENT:	CMS identifies providers using the National Provider Identifier (NPI; effective May 1, 2007), which replaces legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

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CARR_LINE_ANSTHSA_UNIT_CNT

LABEL: Carrier Line Anesthesia Unit Count

DESCRIPTION: The base number of units assigned to the line item anesthesia procedure on the carrier claim (non-DMERC).

SHORT NAME: CARR_LINE_ANSTHSA_UNIT_CNT

LONG NAME: CARR_LINE_ANSTHSA_UNIT_CNT

TYPE: NUM

LENGTH: 2

SOURCE: NCH

VALUES: -

COMMENT: Prior to Version 'J', this field was S9(3), Length 7.3.

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CARR_LINE_CL_CHRG_AMT

LABEL: Carrier Line Clinical Lab Charge Amount
DESCRIPTION: Clinical lab charge amount on the Carrier line.
SHORT NAME: CARR_LINE_CL_CHRG_AMT
LONG NAME: CARR_LINE_CL_CHRG_AMT
TYPE: NUM
LENGTH: 12
SOURCE: NCH
VALUES: XXX.XX
COMMENT: -

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CARR_LINE_CLIA_LAB_NUM

LABEL: Clinical Laboratory Improvement Amendments (CLIA) monitored laboratory number

DESCRIPTION: The identification number assigned to the clinical laboratory providing services for the line item on the carrier claim (non-DMERC).

SHORT NAME: CARR_LINE_CLIA_LAB_NUM

LONG NAME: CARR_LINE_CLIA_LAB_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: -

COMMENT: -

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CARR_LINE_MTUS_CD

LABEL: Carrier Line Miles/Time/Units/Services (MTUS) Indicator Code

DESCRIPTION: Code indicating the units associated with services needing unit reporting on the line item for the carrier claim (non-DMERC).

SHORT NAME: MTUS_IND

LONG NAME: CARR_LINE_MTUS_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

- 0 = Values reported as zero (no allowed activities)
- 1 = Transportation (ambulance) miles
- 2 = Anesthesia time units
- 3 = Services
- 4 = Oxygen units
- 5 = Units of blood

COMMENT: -

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CARR_LINE_MTUS_CNT

LABEL: Carrier Line Miles/Time/Units/Services (MTUS) Count

DESCRIPTION: The count of the total units associated with services needing unit reporting such as transportation, miles, anesthesia time units, number of services, volume of oxygen or blood units.

This is a line item field on the carrier claim (non-DMERC) and is used for both allowed and denied services.

SHORT NAME: MTUS_CNT

LONG NAME: CARR_LINE_MTUS_CNT

TYPE: NUM

LENGTH: 5

SOURCE: NCH

VALUES: -

COMMENT: For anesthesia (MTUS Indicator = 2) this field should be reported in time unit intervals, i.e. 15 minute intervals or fraction thereof.

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CARR_LINE_PRCNG_LCLTY_CD

LABEL: Carrier Line Pricing Locality Code

DESCRIPTION: Code denoting the carrier-specific locality used for pricing the service for this line item on the carrier claim (non-DMERC).

SHORT NAME: LCLTY_CD

LONG NAME: CARR_LINE_PRCNG_LCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: Medicare Localities

There are currently 89 total PFS localities; 34 localities are statewide areas (that is, only one locality for the entire state).

There are 52 localities in the other 16 states, with 10 states having 2 localities, 2 states having 3 localities, 1 state having 4 localities, and 3 states having 5 or more localities.

The District of Columbia, Maryland, and Virginia suburbs, Puerto Rico, and the Virgin Islands are additional localities that make up the remainder of the total of 89 localities.

- 1 = ALABAMA
- 2 = ALASKA
- 3 = ARIZONA
- 4 = ARKANSAS
- 5 = ANAHEIM/SANTA ANA, CA
- 6 = LOS ANGELES, CA
- 7 = MARIN/NAPA/SOLANO, CA
- 8 = OAKLAND/BERKELEY, CA
- 9 = REST OF CALIFORNIA
- 10 = SAN FRANCISCO, CA
- 11 = SAN MATEO, CA
- 12 = SANTA CLARA, CA
- 13 = VENTURA, CA
- 14 = COLORADO
- 15 = CONNECTICUT
- 16 = DC + MD/VA SUBURBS
- 17 = DELAWARE
- 18 = FORT LAUDERDALE, FL
- 19 = MIAMI, FL
- 20 = REST OF FLORIDA
- 21 = ATLANTA, GA

22 = REST OF GEORGIA
 23 = HAWAII
 24 = IDAHO
 25 = CHICAGO, IL
 26 = EAST ST. LOUIS, IL
 27 = REST OF ILLINOIS
 28 = SUBURBAN CHICAGO, IL
 29 = INDIANA
 30 = IOWA
 31 = KANSAS
 32 = KENTUCKY
 33 = NEW ORLEANS, LA
 34 = REST OF LOUISIANA
 35 = REST OF MAINE
 36 = SOUTHERN MAINE
 37 = BALTIMORE/SURR. CNTYS, MD
 38 = REST OF MARYLAND
 39 = METROPOLITAN BOSTON
 40 = REST OF MASSACHUSETTS
 41 = DETROIT, MI
 42 = REST OF MICHIGAN
 43 = MINNESOTA
 44 = MISSISSIPPI
 45 = METROPOLITAN KANSAS CITY, MO
 46 = METROPOLITAN ST. LOUIS, MO
 47 = REST OF MISSOURI
 48 = MONTANA
 49 = NEBRASKA
 50 = NEVADA
 51 = NEW HAMPSHIRE
 52 = NORTHERN NJ
 53 = REST OF NEW JERSEY
 54 = NEW MEXICO
 55 = MANHATTAN, NY
 56 = NYC SUBURBS/LONG I., NY
 57 = POUGHKEPSIE/N NYC SUBURBS, NY
 58 = QUEENS, NY
 59 = REST OF NEW YORK
 60 = NORTH CAROLINA
 61 = NORTH DAKOTA
 62 = OHIO
 63 = OKLAHOMA
 64 = PORTLAND, OR
 65 = REST OF OREGON

- 66 = METROPOLITAN PHILADELPHIA, PA
- 67 = REST OF PENNSYLVANIA
- 68 = PUERTO RICO
- 69 = RHODE ISLAND
- 70 = SOUTH CAROLINA
- 71 = SOUTH DAKOTA
- 72 = TENNESSEE
- 73 = AUSTIN, TX
- 74 = BEAUMONT, TX
- 75 = BRAZORIA, TX
- 76 = DALLAS, TX
- 77 = FORT WORTH, TX
- 78 = GALVESTON, TX
- 79 = HOUSTON, TX
- 80 = REST OF TEXAS
- 81 = UTAH
- 82 = VERMONT
- 83 = VIRGIN ISLANDS
- 84 = VIRGINIA
- 85 = REST OF WASHINGTON
- 86 = SEATTLE (KING CNTY), WA
- 87 = WEST VIRGINIA
- 88 = WISCONSIN
- 89 = WYOMING

COMMENT: -

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CARR_LINE_PRVDR_TYPE_CD

LABEL: Carrier Line Provider Type Code

DESCRIPTION: Code identifying the type of provider furnishing the service for this line item on the carrier claim.

SHORT NAME: PRV_TYPE

LONG NAME: CARR_LINE_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: For Physician/Supplier Claims:

- 0 = Clinics, groups, associations, partnerships, or other entities
- 1 = Physicians or suppliers reporting as solo practitioners
- 2 = Suppliers (other than sole proprietorship)
- 3 = Institutional provider
- 4 = Independent laboratories
- 5 = Clinics (multiple specialties)
- 6 = Groups (single specialty)
- 7 = Other entities

NOTE: PRIOR TO VERSION H, DME claims also used this code; the following were valid code **VALUES:**

- 0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
- 1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
- 2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
- 3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
- 4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
- 5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
- 6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
- 7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
- 8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

COMMENT: -

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CARR_LINE_RDCD_PMT_PHYS_ASTN_C

LABEL:	Carrier Line Reduced Payment Physician Assistant Code
DESCRIPTION:	The code on the carrier (non-DMERC) line item that identifies the line items that have been paid a reduced fee schedule amount (65%, 75% or 85%) because a physician's assistant performed the service.
SHORT NAME:	ASTNT_CD
LONG NAME:	CARR_LINE_RDCD_PMT_PHYS_ASTN_C
TYPE:	CHAR
LENGTH:	1
SOURCE:	NCH
VALUES:	BLANK = Adjustment situation (where CLM_DISP_CD equal 3) 0 = N/A 1 = 65% of payment. Either physician assistants assisting in surgery or nurse midwives 2 = 75% of payment. Either physician assistants performing services in a hospital (other than assisting surgery) or nurse practitioners/clinical nurse specialist performing services in rural areas or clinical social worker services 3 = 85% of payment. Either physician assistant services for other than assisting surgery or other hospital services or nurse practitioners services (not in rural areas)
COMMENT:	-

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CARR_NUM

LABEL: Carrier or MAC Number

DESCRIPTION: The identification number assigned by CMS to a carrier authorized to process claims from a physician or supplier.

Effective July 2006, the Medicare Administrative Contractors (MACs) began replacing the existing carriers and started processing physician or supplier claim records for states assigned to its jurisdiction.

SHORT NAME: CARR_NUM

LONG NAME: CARR_NUM

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: 00510 = Alabama - CAHABA
00511 = Georgia - CAHABA
00512 = Mississippi - CAHABA (eff. 2000)
00520 = Arkansas BC/BS
00521 = New Mexico - Arkansas BC/BS (term. 2008) (replaced by MAC #04202)
00522 = Oklahoma - Arkansas BC/BS (term. 2008) (replaced by MAC #04302)
00523 = Missouri East - Arkansas BC/BS (term. 2008) (replaced by MAC #05392)
00524 = Rhode Island - Arkansas BC/BS (eff. 2004)
00528 = Louisiana - Arkansas BS
00590 = Florida - First Coast
00591 = Connecticut - First Coast (eff. 2000)
00630 = Indiana - Administar
00635 = DMERC-B - Administar (replaced by MAC #17003)
00640 = Iowa - Wellmark, Inc.
00645 = Nebraska - Iowa BS
00650 = Kansas BCBS (term. 2008) (replaced by MAC #05202)
00655 = Nebraska - Kansas BC/BS (term. 2008) (replaced by MAC #05402)
00660 = Kentucky - Administar
00740 = Western Missouri - Kansas BS (term.2008) (replaced by MAC #05302)
00751 = Montana BC/BS (replaced by MAC # 03202)
00801 = New York - Healthnow
00803 = New York - Empire BS
00805 = New Jersey - Empire BS
00811 = DMERC (A) - Healthnow (eff. 2000) (replaced by MAC #16003)
00820 = North Dakota - Noridian (replaced by MAC #03302)
00823 = Utah - Noridian (eff. 12/1/2005) (replaced by MAC #03502)
00824 = Colorado - Noridian (term. 2008) (replaced by MAC #04102)

00825 = Wyoming - Noridian (replaced by MAC #03602)
 00826 = Iowa - Noridian (term. 2008) (replaced by MAC #05102)
 00831 = Alaska - Noridian
 00832 = Arizona - Noridian (replaced by MAC # 03102)
 00833 = Hawaii - Noridian
 00834 = Nevada - Noridian
 00835 = Oregon - Noridian
 00836 = Washington - Noridian
 00865 = Pennsylvania - Highmark
 00870 = Rhode Island BS (term. 2004)
 00880 = South Carolina - Palmetto
 00882 = RRB - South Carolina PGBA (eff. 2000)
 00883 = Ohio - Palmetto (eff. 2002)
 00884 = West Virginia - Palmetto (eff. 2002)
 00885 = DMERC C - Palmetto (replaced by MAC #18003)
 00889 = South Dakota - Noridian (eff. 4/1/2006) (replaced by MAC # 03402)
 00900 = Texas - Trailblazer (term. 2008) (replaced by MAC # 04402)
 00901 = Maryland - Trailblazer
 00902 = Delaware - Trailblazer
 00903 = District of Columbia - Trailblazer
 00904 = Virginia - Trailblazer (eff. 2000)
 00910 = Utah BS
 00951 = Wisconsin - Wisconsin Phy Svc
 00952 = Illinois - Wisconsin Phy Svc
 00953 = Michigan - Wisconsin Phy Svc
 00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
 00973 = Puerto Rico - Triple S, Inc.
 00974 = Triple-S, Inc. - Virgin Islands
 02050 = California - TOLIC (term. 2000)
 05130 = Idaho - CIGNA
 05302 = Western Missouri (eff. 3/2008)
 05440 = Tennessee - CIGNA
 05535 = North Carolina - CIGNA
 05655 = DMERC-D Alaska - CIGNA (replaced by MAC #19003)
 10071 = Railroad Board Travelers (term. 2000)
 10230 = Connecticut - Metra Health (term. 2000)
 10240 = Minnesota - Metra Health (term. 2000)
 10250 = Mississippi - Metra Health (term. 2000)
 10490 = Virginia - Metra Health (term. 2000)
 10555 = DMERC A - Travelers Insurance Co. (term. 2000)
 14330 = New York - GHI
 16360 = Ohio - Nationwide Insurance Co. (term. 2002)
 16510 = West Virginia - Nationwide Insur Co. (term. 2002)
 31140 = N. California - National Heritage Ins.

31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.
31146 = So. California - NHIC (eff. 2000)
80884 = Contractor ID for Physician Risk Adjustment Data (data not sent through NCH,
but through Palmetto)

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#### Medicare Administrative Contractors (MACs)

##### JURISDICTION 3 -- Part B MACs

03102 = Arizona (eff. 12/1/06) (replaces carrier #00832)  
03202 = Montana (eff. 12/1/06) (replaces carrier #00751)  
03302 = N. Dakota (eff. 12/1/06) (replaces carrier #00820)  
03402 = S. Dakota (eff. 12/1/06) (replaces carrier #00889)  
03502 = Utah (eff. 12/1/06) (replaces carrier #00823)  
03602 = Wyoming (eff. 12/1/06) (replaces carrier #00825)

##### JURISDICTION 4 -- Part B MACs

04102 = Colorado (eff. 3/24/08) (replaces carrier #00824)  
04202 = New Mexico (eff. 3/1/08) (replaces carrier #00521)  
04302 = Oklahoma (eff. 3/1/08) (replaces carrier #00522)  
04402 = Texas (eff. 6/13/08) (replaces carrier #00900)

##### JURISDICTION 5 -- Part B MACs

05102 = Iowa (eff. 2/1/08) (replaces carrier #00826)  
05202 = Kansas (eff. 3/1/08) (replaces carrier #00650)  
05302 = W. Missouri (eff. 3/1/08) (replaces carrier #00651 or 00740)  
05392 = E. Missouri (eff. 6/1/08) (replaces carrier #00523)  
05402 = Nebraska (eff. 3/1/08) (replaces carrier #00655)

#### Durable Medical Equipment (DME) MACs

16003 = National Heritage Insur Co (NHIC) (eff. 7/1/06) (replaces carrier #00811)  
17003 = Administar Federal, Inc. (eff. 7/1/06) (replaces carrier # 00635)  
18003 = Palmetto GBA, LLC (eff. 6/1/07) (replaces carrier #00885)  
19003 = Noridan Administrative Services (eff. 10/1/06) (replaces carrier #05655)

**COMMENT:** Prior to Version H this field was named: FICARR\_IDENT\_NUM.

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## CARRXNUM

**LABEL:** Carrier Line RX Number

**DESCRIPTION:** The number used to identify the prescription order number for drugs and biologicals purchased through the competitive acquisition program (CAP).

**SHORT NAME:** CARRXNUM

**LONG NAME:** CARR\_LINE\_RX\_NUM

**TYPE:** CHAR

**LENGTH:** 30

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** The prescription order number consists of:

--Vendor ID Number (positions 1 - 4)

--HCPCS Code (positions 5 - 9)

--Vendor Controlled Prescription Number (positions 10 - 30)

The Medicare Modernization Act (MMA) required CMS to implement at a competitive acquisition program (CAP) for Part B drugs and biologicals not paid on a cost or PPS basis. Physicians have a choice between buying and billing these drugs under the average sales price (ASP) or obtaining these drugs from an approved CAP vendor. The prescription number is needed to identify which claims were submitted for CAP drugs and their administration.

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## CARR\_PRFRNG\_PIN\_NUM

|                     |                                                                                                                                                                                           |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Carrier Line Performing Provider ID Number (PIN)                                                                                                                                          |
| <b>DESCRIPTION:</b> | The provider identification number (PIN) of the physician/supplier (assigned by the Medicare Administrative Contractor [MAC]) who performed the service for this line item.               |
| <b>SHORT NAME:</b>  | PRF_PRFL                                                                                                                                                                                  |
| <b>LONG NAME:</b>   | CARR_PRFRNG_PIN_NUM                                                                                                                                                                       |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                      |
| <b>LENGTH:</b>      | 15                                                                                                                                                                                        |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                       |
| <b>VALUES:</b>      | -                                                                                                                                                                                         |
| <b>COMMENT:</b>     | CMS identifies providers using the National Provider Identifier (NPI; effective May 1, 2007), which replaces legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions. |

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## CLAIM\_QUERY\_CD

**LABEL:** Claim Query Code

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

**SHORT NAME:** QUERY\_CD

**LONG NAME:** CLAIM\_QUERY\_CODE

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                  |
|-----|------------------|
| 1 = | Interim bill     |
| 3 = | Final bill       |
| 5 = | Debit adjustment |

**COMMENT:** -

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## CLM\_ADMSN\_DT

**LABEL:** Claim Admission Date

**DESCRIPTION:** On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or religious non-medical health care institution. When this variable appears in the HHA claims (Short Name = HHSTRDT), it is the date the care began for the HHA services reported on the claim.

The date in this variable may precede the claim from date (CLM\_FROM\_DT) if this claim is for a beneficiary who has been continuously under care.

**SHORT NAME:** ADMSN\_DT

**LONG NAME:** CLM\_ADMSN\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** In HHA claims, this is the date the home health plan was established or last reviewed.

This field is not well populated in HHA until after 2011.

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## CLM\_BASE\_OPRTG\_DRG\_AMT

|                     |                                                                                           |
|---------------------|-------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Base Operating DRG Amount                                                           |
| <b>DESCRIPTION:</b> | The amount of the wage-adjusted DRG operating payment plus the technology add-on payment. |
| <b>SHORT NAME:</b>  | CLM_BASE_OPRTG_DRG_AMT                                                                    |
| <b>LONG NAME:</b>   | CLM_BASE_OPRTG_DRG_AMT                                                                    |
| <b>TYPE:</b>        | NUM                                                                                       |
| <b>LENGTH:</b>      | 12                                                                                        |
| <b>SOURCE:</b>      | NCH                                                                                       |
| <b>VALUES:</b>      | -                                                                                         |
| <b>COMMENT:</b>     | This variable was new in 2011.<br>It is populated only for Inpatient claims.              |

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## CLM\_BENE\_PD\_AMT

**LABEL:** Carrier Claim Beneficiary Paid Amount

**DESCRIPTION:** The amount paid by the beneficiary for the non-institutional Part B (carrier, or DMERC) claim.

**SHORT NAME:** CLM\_BENE\_PD\_AMT

**LONG NAME:** CLM\_BENE\_PD\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## CLM\_BNDLD\_ADJSTMT\_PMT\_AMT

|                     |                                                                                                                                                                                                                                                                                                                                                       |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Bundled Adjustment Payment Amount                                                                                                                                                                                                                                                                                                               |
| <b>DESCRIPTION:</b> | This field represents the amount the claim was reduced for those hospitals participating in Model 1 of the Bundled Payments for Care Improvement initiative (BPCI, Model 1).                                                                                                                                                                          |
| <b>SHORT NAME:</b>  | CLM_BNDLD_ADJSTMT_PMT_AMT                                                                                                                                                                                                                                                                                                                             |
| <b>LONG NAME:</b>   | CLM_BNDLD_ADJSTMT_PMT_AMT                                                                                                                                                                                                                                                                                                                             |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                                                                                                                                                                   |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                                                                                                                                                                    |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                   |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                                                                                                                                                                |
| <b>COMMENT:</b>     | <p>The hospital must be participating in the Model 1 of the Bundled Payments for Care Improvement initiative (refer to CLM_CARE_IMPRVMT_MODEL_CD1). The percentage of the discount that this amount represents is in the field called CLM_BNDLD_MODEL_1_DSCNT_PCT.</p> <p>This field was new in 2013, and is null/missing for all previous years.</p> |

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## CLM\_BNDLD\_MODEL\_1\_DSCNT\_PCT

**LABEL:** Claim Bundled Model 1 Discount Percent

**DESCRIPTION:** This field identifies the discount percentage which will be applied to payment for all participating hospitals' DRG over the lifetime of the Bundled Payments for Care Improvement initiative (BPCI, Model 1).

**SHORT NAME:** CLM\_BNDLD\_MODEL\_1\_DSCNT\_PCT

**LONG NAME:** CLM\_BNDLD\_MODEL\_1\_DSCNT\_PCT

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** X.XX

**COMMENT:** The hospital must be participating in the Model 1 of the BPCI (refer to CLM\_CARE\_IMPRVMT\_MODEL\_CD1). The dollar amount of the payment reduction for the service is in the field called CLM\_BNDLD\_ADJSTMT\_PMT\_AMT.

This field was new in 2013, and is null/missing for all previous years.

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## CLM\_CARE\_IMPRVMT\_MODEL\_CD1

|                     |                                                                                                                                                                                                             |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Care Improvement Model 1 Code (bundled payment)                                                                                                                                                       |
| <b>DESCRIPTION:</b> | This code is used to identify that the care improvement model 1 is being used for bundling payments. The initiative is referred to as the Bundled Payments for Care Improvement initiative (BPCI, Model 1). |
| <b>SHORT NAME:</b>  | CLM_CARE_IMPRVMT_MODEL_CD1                                                                                                                                                                                  |
| <b>LONG NAME:</b>   | CLM_CARE_IMPRVMT_MODEL_CD1                                                                                                                                                                                  |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                        |
| <b>LENGTH:</b>      | 2                                                                                                                                                                                                           |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                         |
| <b>VALUES:</b>      | 61 = Care Improvement Model 1 is used<br>Null/missing                                                                                                                                                       |
| <b>COMMENT:</b>     | There are 4 of these Care Improvement Model fields<br>(CLM_CARE_IMPRVMT_MODEL_CD1-CLM_CARE_IMPRVMT_MODEL_CD4).<br><br>This field was new in 2013, and is null/missing for all previous years.               |

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## CLM\_CARE\_IMPRVMT\_MODEL\_CD2

|                     |                                                                                                                                                                                               |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Care Improvement Model 2 Code                                                                                                                                                           |
| <b>DESCRIPTION:</b> | This code is used to identify that the care improvement model 2 is being used for payments.                                                                                                   |
| <b>SHORT NAME:</b>  | CLM_CARE_IMPRVMT_MODEL_CD2                                                                                                                                                                    |
| <b>LONG NAME:</b>   | CLM_CARE_IMPRVMT_MODEL_CD2                                                                                                                                                                    |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                          |
| <b>LENGTH:</b>      | 2                                                                                                                                                                                             |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                           |
| <b>VALUES:</b>      | 62 = Care Improvement Model 2 is used<br>Null/missing                                                                                                                                         |
| <b>COMMENT:</b>     | There are 4 of these Care Improvement Model fields<br>(CLM_CARE_IMPRVMT_MODEL_CD1-CLM_CARE_IMPRVMT_MODEL_CD4).<br><br>This field was new in 2013, and is null/missing for all previous years. |

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### CLM\_CARE\_IMPRVMT\_MODEL\_CD3

|                     |                                                                                                                                                                                               |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Care Improvement Model 3 Code                                                                                                                                                           |
| <b>DESCRIPTION:</b> | This code is used to identify that the care improvement model 3 is being used for payments.                                                                                                   |
| <b>SHORT NAME:</b>  | CLM_CARE_IMPRVMT_MODEL_CD3                                                                                                                                                                    |
| <b>LONG NAME:</b>   | CLM_CARE_IMPRVMT_MODEL_CD3                                                                                                                                                                    |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                          |
| <b>LENGTH:</b>      | 2                                                                                                                                                                                             |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                           |
| <b>VALUES:</b>      | 63 = Care Improvement Model 3 is used<br>Null/missing                                                                                                                                         |
| <b>COMMENT:</b>     | There are 4 of these Care Improvement Model fields<br>(CLM_CARE_IMPRVMT_MODEL_CD1-CLM_CARE_IMPRVMT_MODEL_CD4).<br><br>This field was new in 2013, and is null/missing for all previous years. |

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## CLM\_CARE\_IMPRVMT\_MODEL\_CD4

|                     |                                                                                                                                                                                               |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Care Improvement Model 4 Code                                                                                                                                                           |
| <b>DESCRIPTION:</b> | This code is used to identify that the care improvement model 4 is being used for payments.                                                                                                   |
| <b>SHORT NAME:</b>  | CLM_CARE_IMPRVMT_MODEL_CD4                                                                                                                                                                    |
| <b>LONG NAME:</b>   | CLM_CARE_IMPRVMT_MODEL_CD4                                                                                                                                                                    |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                          |
| <b>LENGTH:</b>      | 2                                                                                                                                                                                             |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                           |
| <b>VALUES:</b>      | 64 = Care Improvement Model 4 is used<br>Null/missing                                                                                                                                         |
| <b>COMMENT:</b>     | There are 4 of these Care Improvement Model fields<br>(CLM_CARE_IMPRVMT_MODEL_CD1-CLM_CARE_IMPRVMT_MODEL_CD4).<br><br>This field was new in 2013, and is null/missing for all previous years. |

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## CLM\_CLNCL\_TRIL\_NUM

**LABEL:** Clinical Trial Number

**DESCRIPTION:** The number used to identify all items and line item services provided to a beneficiary during their participation in a clinical trial.

**SHORT NAME:** CCLTRNUM

**LONG NAME:** CLM\_CLNCL\_TRIL\_NUM

**TYPE:** CHAR

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** CMS is requesting the clinical trial number be voluntarily reported. The number is assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered.

Effective September 1, 2008 with the implementation of CR#3.

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## CLM\_DISP\_CD

**LABEL:** Claim Disposition Code

**DESCRIPTION:** Code indicating the disposition or outcome of the processing of the claim record.

In the source CMS National Claims History (NCH), claims are transactional records and several iterations of the claim may exist (e.g., original claim, an edited/updated version - which also cancels the original claim, etc.).

The final reconciled version of the claim is contained in CCW-produced data files, unless otherwise requested. For final claims (at least those that are final at the time of the data file), this value will always be '01'.

**SHORT NAME:** DISP\_CD

**LONG NAME:** CLM\_DISP\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:** 01 = Debit accepted

**COMMENT:** -

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## CLM\_DRG\_CD

**LABEL:** Claim Diagnosis Related Group Code (or MS-DRG Code)

**DESCRIPTION:** The diagnostic related group to which a hospital claim belongs for prospective payment purposes.

**SHORT NAME:** DRG\_CD

**LONG NAME:** CLM\_DRG\_CD

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** -

**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 to base the reimbursement to the hospitals under prospective payment.

Nonpayment claims (zero reimbursement) may not have a DRG present.

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## CLM\_DRG\_OUTLIER\_STAY\_CD

**LABEL:** Claim Diagnosis Related Group Outlier Stay Code

**DESCRIPTION:** On an institutional claim, the code that indicates the beneficiary stay under the prospective payment system (PPS) which, although classified into a specific diagnosis related group, has an unusually long length (day outlier) or exceptionally high cost (cost outlier).

**SHORT NAME:** OUTLR\_CD

**LONG NAME:** CLM\_DRG\_OUTLIER\_STAY\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                  |
|-----|----------------------------------|
| 0 = | No outlier                       |
| 1 = | Day outlier (condition code 60)  |
| 2 = | Cost outlier (condition code 61) |

\*\*\* Non-PPS Only \*\*\*

|     |                                                                     |
|-----|---------------------------------------------------------------------|
| 6 = | Valid diagnosis related groups (DRG) received from the intermediary |
| 7 = | CMS developed DRG                                                   |
| 8 = | CMS developed DRG using patient status code                         |
| 9 = | Not groupable                                                       |

**COMMENT:** -

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## CLM\_E\_POA\_IND\_SW1

**LABEL:** Claim Diagnosis E Code I Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW1

**LONG NAME:** CLM\_E\_POA\_IND\_SW1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW2

**LABEL:** Claim Diagnosis E Code II Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW2

**LONG NAME:** CLM\_E\_POA\_IND\_SW2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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### CLM\_E\_POA\_IND\_SW3

**LABEL:** Claim Diagnosis E Code III Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW3

**LONG NAME:** CLM\_E\_POA\_IND\_SW3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW4

**LABEL:** Claim Diagnosis E Code IV Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW4

**LONG NAME:** CLM\_E\_POA\_IND\_SW4

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW5

**LABEL:** Claim Diagnosis E Code V Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW5

**LONG NAME:** CLM\_E\_POA\_IND\_SW5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW6

**LABEL:** Claim Diagnosis E Code VI Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW6

**LONG NAME:** CLM\_E\_POA\_IND\_SW6

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW7

**LABEL:** Claim Diagnosis E Code VII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW7

**LONG NAME:** CLM\_E\_POA\_IND\_SW7

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW8

**LABEL:** Claim Diagnosis E Code VIII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW8

**LONG NAME:** CLM\_E\_POA\_IND\_SW8

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW9

**LABEL:** Claim Diagnosis E Code IX Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW9

**LONG NAME:** CLM\_E\_POA\_IND\_SW9

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW10

**LABEL:** Claim Diagnosis E Code X Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW10

**LONG NAME:** CLM\_E\_POA\_IND\_SW10

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW11

**LABEL:** Claim Diagnosis E Code XI Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW11

**LONG NAME:** CLM\_E\_POA\_IND\_SW11

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_E\_POA\_IND\_SW12

**LABEL:** Claim Diagnosis E Code XII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_E\_POA\_IND\_SW12

**LONG NAME:** CLM\_E\_POA\_IND\_SW12

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                                                                                                 |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y = | Diagnosis was present at the time of admission (POA)                                                                                                                            |
| N = | Diagnosis was not present at the time of admission                                                                                                                              |
| U = | Documentation is insufficient to determine if condition was present on admission                                                                                                |
| W = | Provider is unable to clinically determine whether condition was present on admission                                                                                           |
| 1 = | Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data |
| Z = | Denotes the end of the POA indicators                                                                                                                                           |
| X = | Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.                                                        |

**COMMENT:** Medicare claims did not indicate whether a diagnosis was POA until 2011.

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## CLM\_FAC\_TYPE\_CD

**LABEL:** Claim Facility Type Code

**DESCRIPTION:** The type of facility.

**SHORT NAME:** FAC\_TYPE

**LONG NAME:** CLM\_FAC\_TYPE\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 1 = Hospital
- 2 = Skilled Nursing Facility (SNF)
- 3 = Home Health Agency (HHA)
- 4 = Religious Non-medical (hospital)
- 6 = Intermediate Care (IMC)
- 7 = Clinic services or hospital-based renal dialysis facility
- 8 = Ambulatory Surgery Center (ASC) or other special facility (e.g. hospice)

**COMMENT:** This field, in combination with the service classification type code (variable called CLM\_SRVC\_CLSFCTN\_TYPE\_CD) indicates the “type of bill” for an institutional claim. Many different types of services can be billed on a Part A or Part B institutional claim, and knowing the type of bill helps to distinguish them.

The type of bill is the concatenation of two variables:

- facility type (CLM\_FAC\_TYPE\_CD)

- service classification type (CLM\_SRVC\_CLSFCTN\_TYPE\_CD).

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## CLM\_FREQ\_CD

**LABEL:** Claim Frequency Code

**DESCRIPTION:** 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.

**SHORT NAME:** FREQ\_CD

**LONG NAME:** CLM\_FREQ\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                   |
|-----|-------------------------------------------------------------------|
| 0 = | Non-payment/zero claims                                           |
| 1 = | Admit thru discharge claim                                        |
| 2 = | Interim – first claim                                             |
| 3 = | Interim – continuing claim                                        |
| 4 = | Interim – last claim                                              |
| 5 = | Late charge(s) only claim                                         |
| 7 = | Replacement of prior claim                                        |
| 8 = | Void/cancel prior claim                                           |
| 9 = | Final claim (for HH PPS = process as a debit/credit to RAP claim) |
| G = | Common Working File (NCH) generated adjustment claim              |
| H = | CMS generated adjustment claim                                    |
| I = | Misc. adjustment claim (e.g., initiated by intermediary or QIO)   |
| J = | Other adjustment request                                          |
| M = | Medicare secondary payer (MSP) adjustment                         |
| P = | Adjustment required by QIO                                        |

**COMMENT:** This field can be used in determining the "type of bill" for an institutional claim. Often type of bill consists of a combination of two variables: the facility type code (variable called CLM\_FAC\_TYPE\_CD) and the service classification type code (CLM\_SRVC\_CLSFCTN\_TYPE\_CD). This variable serves as the optional third component of bill type, and it is helpful for distinguishing between final, interim, or RAP (request for anticipated payment) claims - which is particularly helpful if you receive claims that are not "final action".

Many different types of services can be billed on a Part A or Part B institutional claim, and knowing the type of bill helps to distinguish them. The type of bill is the concatenation of three variables : the facility type (CLM\_FAC\_TYPE\_CD), the service classification type code (CLM\_SRVC\_CLSFCTN\_TYPE\_CD), and the claim frequency code (CLM\_FREQ\_CD).

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## CLM\_FULL\_STD\_PYMT\_AMT

**LABEL:** Claim Full Standard Payment Amount

**DESCRIPTION:** This variable is the standard payment amount for long-term care hospitals (LTCH) under the Medicare prospective payment system (PPS), which is based on the MS-LTC-DRG.

This amount does not include any applicable outlier payment amount.

**SHORT NAME:** CLM\_FULL\_STD\_PYMT\_AMT

**LONG NAME:** CLM\_FULL\_STD\_PYMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Applies only to Inpatient (LTCH) claims. This field is new in October 2015.

For a LTCH PPS claim, only one of four fields will be populated (CLM\_SITE\_NTRL\_PYMT\_CST\_AMT, CLM\_SITE\_NTRL\_PYMT\_IPPS\_AMT, CLM\_FULL\_STD\_PYMT\_AMT, or CLM\_SS\_OUTLIER\_STD\_PYMT\_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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## CLM\_HHA\_LUPA\_IND\_CD

|                     |                                                                                                                                                                                                                                                                                   |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code                                                                                                                                                                                                                |
| <b>DESCRIPTION:</b> | <p>The code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode.</p> <p>If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of Home Health resource groups (HHRGs).</p> |
| <b>SHORT NAME:</b>  | LUPAIND                                                                                                                                                                                                                                                                           |
| <b>LONG NAME:</b>   | CLM_HHA_LUPA_IND_CD                                                                                                                                                                                                                                                               |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                              |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                                                                                                                 |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                               |
| <b>VALUES:</b>      | <p>L = Low utilization payment adjustment (LUPA) claim</p> <p>Blank = Not a LUPA claim; process using Home Health resource groups (HHRG)</p>                                                                                                                                      |
| <b>COMMENT:</b>     | Beginning 10/1/00, this field was populated with data. Claims processed prior to 10/1/00 contained spaces.                                                                                                                                                                        |

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## CLM\_HHA\_RFRL\_CD

**LABEL:** Claim HHA Referral Code

**DESCRIPTION:** Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for Home Health services.

**SHORT NAME:** HHA\_RFRL

**LONG NAME:** CLM\_HHA\_RFRL\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.
- 2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
- 3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
- 4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility.
- 5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.
- 6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.
- 7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.
- 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
- 9 = Information not available - The means by which the patient was admitted is not known.
- A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital
- B = Transfer from another HHA – Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff.10/00)



C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then readmitted within the original 60-day episode, the original episode must be closed early and a new one created.

**COMMENT:** The use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00)

Beginning 10/1/00, this field was populated with data. Claims processed prior to 10/1/00 contained spaces in this field.

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## CLM\_HHA\_TOT\_VISIT\_CNT

**LABEL:** Claim HHA Total Visit Count

**DESCRIPTION:** The count of the number of HHA visits as derived by CMS.

**SHORT NAME:** VISITCNT

**LONG NAME:** CLM\_HHA\_TOT\_VISIT\_CNT

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** 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'.

Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.

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## CLM\_HOSP\_START\_DT\_ID

**LABEL:** Claim Hospice Start Date

**DESCRIPTION:** On an institutional claim, the date the beneficiary was admitted to the hospice care.

**SHORT NAME:** HSPCSTRT

**LONG NAME:** CLM\_HOSPC\_START\_DT\_ID

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## CLM\_HRR\_ADJSTMT\_PCT

**LABEL:** Claim HRR Adjustment Percent

**DESCRIPTION:** Under the Hospital Readmissions Reduction (HRR) Program, the amount used to identify the readmission adjustment factor that will be applied.

**SHORT NAME:** CLM\_HRR\_ADJSTMT\_PCT

**LONG NAME:** CLM\_HRR\_ADJSTMT\_PCT

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** X.XXXX

**COMMENT:** The ACA (Section 3025) requires CMS to reduce payments to subsection (d) Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions. There is a variable that indicates whether the hospital was excluded from the HRR program (see CLM\_HRR\_PRTCPNT\_IND\_CD). This percentage reduction is applied to the base operating DRG amount (defined as the wage-adjusted DRG payment plus new technology add-on payments).

Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

The actual dollar amount of the adjustment that applied to the claim is found in the variable called CLM\_HRR\_ADJSTMT\_PMT\_AMT.

This initiative began in 4th Quarter of 2012 (i.e., beginning of Federal fiscal year 13).

This field was new in 2012, and is null/missing for all previous years.

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## CLM\_HRR\_ADJSTMT\_PMT\_AMT

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Hospital Readmission Reduction (HRR) Adjustment Payment Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>DESCRIPTION:</b> | This field represents the Hospital Readmission Reduction (HRR) Program Payment Amount. The amount is the reduction to the claim for a readmission.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>SHORT NAME:</b>  | CLM_HRR_ADJSTMT_PMT_AMT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>LONG NAME:</b>   | CLM_HRR_ADJSTMT_PMT_AMT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>VALUES:</b>      | XXX.XX (may be a negative value)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>COMMENT:</b>     | <p>The ACA (Section 3025) requires CMS to reduce payments to subsection (d) Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions. There is a variable that indicates whether the hospital was excluded from the HRR program (see CLM_HRR_PRTCPNT_IND_CD). This percentage reduction is applied to the base operating DRG amount(defined as the wage-adjusted DRG payment plus new technology add-on payments).</p> <p>Additional information is available on the CMS "Hospital Value-Based Purchasing" website.</p> <p>This amount is based on a percent (CLM_HRR_ADJSTMT_PCT).</p> <p>This initiative began in 4th Quarter of 2012 (i.e., beginning of Federal fiscal year 13).</p> <p>This field was new in 2012, and is null/missing for all previous years.</p> |

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## CLM\_HRR\_PRTCPNT\_IND\_CD

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Hospital Readmission Reduction (HRR) Participant Indicator Code                                                                                                                                                                                                                                                                                                                                                             |
| <b>DESCRIPTION:</b> | This field is the code used to identify whether the hospital is participating in the Hospital Readmissions Reduction (HRR) program.                                                                                                                                                                                                                                                                                               |
| <b>SHORT NAME:</b>  | CLM_HRR_PRTCPNT_IND_CD                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>LONG NAME:</b>   | CLM_HRR_PRTCPNT_IND_CD                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>VALUES:</b>      | 0 = Not participating<br>1 = Participating and not equal to 1.0000<br>2 = Participating and equal to 1.0000<br>Null/missing = Not participating                                                                                                                                                                                                                                                                                   |
| <b>COMMENT:</b>     | <p>The ACA (Section 3025) requires CMS to reduce payments to Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions.</p> <p>Additional information is available on the CMS "Hospital Value-Based Purchasing" website.</p> <p>This initiative began in 4th Quarter of 2012 (i.e., beginning of Federal fiscal year 13).</p> <p>This field was new in 2012, and is null/missing for all previous years.</p> |

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## CLM\_ID

**LABEL:** Claim ID

**DESCRIPTION:** This is the unique identification number for the claim.

Each Part A or institutional Part B claim has at least one revenue center record.

Each non-institutional Part B claim has at least one claim line.

All revenue center records or claim lines on a given claim have the same CLM\_ID. It is used to link the revenue lines together and/or to the base claim.

**SHORT NAME:** CLM\_ID

**LONG NAME:** CLM\_ID

**TYPE:** CHAR

**LENGTH:** 15

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** Limitation: When pulled directly from the CCW database, this is a numeric column.

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## CLM\_IP\_ADMSN\_TYPE\_CD

**LABEL:** Claim Inpatient Admission Type Code

**DESCRIPTION:** The code indicating the type and priority of an inpatient admission associated with the service on an intermediary submitted claim.

**SHORT NAME:** TYPE\_ADM

**LONG NAME:** CLM\_IP\_ADMSN\_TYPE\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 0 = Unknown Value (but present in data)
- 1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
- 2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
- 3 = Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations.
- 4 = Newborn - Necessitates the use of special source of admission codes.
- 5 = Trauma Center - visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
- 6 = Reserved
- 7 = Reserved
- 8 = Reserved
- 9 = Unknown - Information not available.

**COMMENT:** -

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## CLM\_IP\_LOW\_VOL\_PMT\_AMT

**LABEL:** Claim Inpatient Low Volume Payment Amount

**DESCRIPTION:** This is the amount field used to identify a payment adjustment given to hospitals to account for the higher costs per discharge for low income hospitals under the Inpatient Prospective Payment System (IPPS).

**SHORT NAME:** CLM\_IP\_LOW\_VOL\_PMT\_AMT

**LONG NAME:** CLM\_IP\_LOW\_VOL\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Payment adjustment for low income IPPS hospitals.  
This field was new in 2011.

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## CLM\_LINE\_NUM

**LABEL:** Claim Line Number

**DESCRIPTION:** This variable identifies an individual line number on a claim.

Each revenue center record or claim line has a sequential line number to distinguish distinct services that are submitted on the same claim.

All revenue center records or claim lines on a given claim have the same CLM\_ID.

**SHORT NAME:** CLM\_LN

**LONG NAME:** CLM\_LINE\_NUM

**TYPE:** NUM

**LENGTH:** 13

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** -

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## CLM\_MCO\_PD\_SW

**LABEL:** Claim MCO Paid Switch

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

**SHORT NAME:** MCOPDSW

**LONG NAME:** CLM\_MCO\_PD\_SW

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = No managed care organization (MCO) payment  
0 = No managed care organization (MCO) payment  
1 = MCO paid provider for the claim

**COMMENT:** -

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## CLM\_MDCL\_REC

**LABEL:** Claim Medical Record Number

**DESCRIPTION:** The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.

**SHORT NAME:** CLM\_MDCL\_REC

**LONG NAME:** CLM\_MDCL\_REC

**TYPE:** CHAR

**LENGTH:** 17

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** This variable may be null/missing.

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## CLM\_MDCR\_NON\_PMT\_RSN\_CD

**LABEL:** Claim Medicare Non Payment Reason Code

**DESCRIPTION:** The reason that no Medicare payment is made for services on an institutional claim.

**SHORT NAME:** NOPAY\_CD

**LONG NAME:** CLM\_MDCR\_NON\_PMT\_RSN\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- A = Covered worker's compensation (Obsolete)
- B = Benefit exhausted
- C = Custodial care – non-covered care (includes all 'beneficiary at fault' waiver cases) (Obsolete)
- E = HMO out-of-plan services not emergency or urgently needed (Obsolete)
- E = MSP cost avoided - IRS/SSA/HCFR Data Match (eff. 7/00)
- F = MSP cost avoid HMO Rate Cell (eff. 7/00)
- G = MSP cost avoided Litigation Settlement (eff. 7/00)
- H = MSP cost avoided Employer Voluntary Reporting (eff. 7/00)
- J = MSP cost avoid Insurer Voluntary Reporting (eff. 7/00)
- K = MSP cost avoid Initial Enrollment Questionnaire (eff. 7/00)
- N = All other reasons for non-payment
- P = Payment requested
- Q = MSP cost avoided Voluntary Agreement (eff. 7/00)
- R = Benefits refused, or evidence not submitted
- T = MSP cost avoided - IEQ contractor (eff. 9/76) (obsolete 6/30/00)
- U = MSP cost avoided - HMO rate cell adjustment (eff. 9/76) (Obsolete 6/30/00)
- V = MSP cost avoided - litigation settlement (eff. 9/76) (Obsolete 6/30/00)
- W = Worker's compensation (Obsolete)
- X = MSP cost avoided - generic
- Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)
- Z = Zero reimbursement RAPs -- zero reimbursement made due to medical review intervention or where provider specific zero payment has been determined. (effective with HHPPS - 10/00)
- 00 = MSP cost avoided - COB Contractor
- 12 = MSP cost avoided - BCBS Voluntary Agreements
- 13 = MSP cost avoided - Office of Personnel Management
- 14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
- 15 = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)
- 16 = MSP cost avoided - Liability Insurer VDSA (eff. 4/2006)
- 17 = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006)

- 18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006)
- 19 = SEE NOTE4: Coordination of Benefits Contractor 11119 (see CMS Change Request 7906 for identification of the contractor.)
- 21 = MSP cost avoided - MIR Group Health Plan (eff. 1/2009)
- 22 = MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009)
- 25 = MSP cost avoided - Recovery Audit Contractor - California (eff. 10/2005)
- 26 = MSP cost avoided - Recovery Audit Contractor - Florida (eff. 10/2005)
- 42 = SEE NOTE4: Coordination of Benefits Contractor 11142 (see CMS Change Request 7906 for identification of the contractor.)
- 43 = SEE NOTE4: Coordination of Benefits Contractor 11143 (see CMS Change Request 7906 for identification of the contractor.)

Effective 4/1/02, the Medicare nonpayment reason code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

- ! = MSP cost avoided - COB Contractor ('00' 2-byte code)
- @ = MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code)
- # = MSP cost avoided - Office of Personnel Management ('13' 2-byte code)
- \$ = MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code)
- \* = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006)
- ( = MSP cost avoided - Liability Insurer VDSA ('16' 2-byte code) (eff. 4/2006)
- ) = MSP cost avoided - No-Fault Insurer VDSA ('17' 2-byte code) (eff. 4/2006)
- + = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement ('18' 2-byte code) (eff. 4/2006)
- < = MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009)
- > = MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009)
- % = MSP cost avoided - Recovery Audit Contractor - California ('25' 2-byte code) (eff. 10/2005)
- & = MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)

**COMMENT:** This field was put on all institutional claim types but data did not start coming in on OP/HHA/Hospice until 4/1/02. Prior to 4/1/02, data only came in Inpatient/SNF claims.

Effective 4/1/02, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE3: Effective with Version 'J', the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two byte values being sent in by NCH since 4/2002.

During the Version 'J' conversion, all character values were converted to the two byte values.

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## CLM\_MODEL\_4\_READMSN\_IND\_CD

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Model 4 Readmission Indicator Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>DESCRIPTION:</b> | This field identifies the method of payment of a claim billed within 30 days of a Model 4 Bundled Payments for Care Improvement (BPCI) admission.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>SHORT NAME:</b>  | CLM_MODEL_4_READMSN_IND_CD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>LONG NAME:</b>   | CLM_MODEL_4_READMSN_IND_CD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>VALUES:</b>      | <p>1 = claim is related readmission to a Model 4 BPCI claim and shall pay IME, DSH, and Capital Only.</p> <p>2 = two Model 4 BPCI claims within 30 days of each other, first claim in episode shall process as it would in the absence of Model 4 BPCI.</p> <p>3 = two Model 4 BPCI claims within 30 days of each other, this is the second claim in the episode and paid as Model 4.</p> <p>Null/missing = not a BPCI claim</p>                                                                                                                                                                                                                   |
| <b>COMMENT:</b>     | Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients. Under the Model 4 BPCI pilot, CMS will reimburse qualified acute care hospitals a blended payment for hospital inpatient care and physician services connected with a single episode of care. This will occur in association with inpatient hospital claims that the BPCI participating hospital will bill to their jurisdictional A/B MAC as type of bill 11X claims. |

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## CLM\_NEXT\_GNRTN\_ACO\_IND\_CD1

|                     |                                                                                                                                                                                        |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code – Population-Based Payment (PBP)                                                                         |
| <b>DESCRIPTION:</b> | The field identifies the claims that qualify for specific claims processing edits related to benefit enhancement through the Next Generation (NG) Accountable Care Organization (ACO). |
| <b>SHORT NAME:</b>  | CLM_NEXT_GNRTN_ACO_IND_CD1                                                                                                                                                             |
| <b>LONG NAME:</b>   | CLM_NEXT_GNRTN_ACO_IND_CD1                                                                                                                                                             |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                   |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                      |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                    |
| <b>VALUES:</b>      | 0 = Base record (no enhancements)<br>1 = Population Based Payments (PBP)<br>2 = Telehealth<br>3 = Post Discharge Home Health Visits<br>4 = 3-Day SNF Waiver<br>5 = Capitation          |
| <b>COMMENT:</b>     | There are 5 of these ACO fields (CLM_NEXT_GNRTN_ACO_IND_CD1 - CLM_NEXT_GNRTN_ACO_IND_CD5).                                                                                             |

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## CLM\_NEXT\_GNRTN\_ACO\_IND\_CD2

|                     |                                                                                                                                                                                        |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code – Telehealth                                                                                             |
| <b>DESCRIPTION:</b> | The field identifies the claims that qualify for specific claims processing edits related to benefit enhancement through the Next Generation (NG) Accountable Care Organization (ACO). |
| <b>SHORT NAME:</b>  | CLM_NEXT_GNRTN_ACO_IND_CD2                                                                                                                                                             |
| <b>LONG NAME:</b>   | CLM_NEXT_GNRTN_ACO_IND_CD2                                                                                                                                                             |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                   |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                      |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                    |
| <b>VALUES:</b>      | 0 = Base record (no enhancements)<br>1 = Population Based Payments (PBP)<br>2 = Telehealth<br>3 = Post Discharge Home Health Visits<br>4 = 3-Day SNF Waiver<br>5 = Capitation          |
| <b>COMMENT:</b>     | There are 5 of these ACO fields (CLM_NEXT_GNRTN_ACO_IND_CD1 - CLM_NEXT_GNRTN_ACO_IND_CD5).                                                                                             |

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### CLM\_NEXT\_GNRTN\_ACO\_IND\_CD3

|                     |                                                                                                                                                                                        |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code – Post-discharge HH visits                                                                               |
| <b>DESCRIPTION:</b> | The field identifies the claims that qualify for specific claims processing edits related to benefit enhancement through the Next Generation (NG) Accountable Care Organization (ACO). |
| <b>SHORT NAME:</b>  | CLM_NEXT_GNRTN_ACO_IND_CD3                                                                                                                                                             |
| <b>LONG NAME:</b>   | CLM_NEXT_GNRTN_ACO_IND_CD3                                                                                                                                                             |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                   |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                      |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                    |
| <b>VALUES:</b>      | 0 = Base record (no enhancements)<br>1 = Population Based Payments (PBP)<br>2 = Telehealth<br>3 = Post Discharge Home Health Visits<br>4 = 3-Day SNF Waiver<br>5 = Capitation          |
| <b>COMMENT:</b>     | There are 5 of these ACO fields (CLM_NEXT_GNRTN_ACO_IND_CD1 - CLM_NEXT_GNRTN_ACO_IND_CD5).                                                                                             |

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#### CLM\_NEXT\_GNRTN\_ACO\_IND\_CD4

|                     |                                                                                                                                                                                        |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code – 3-day SNF waiver                                                                                       |
| <b>DESCRIPTION:</b> | The field identifies the claims that qualify for specific claims processing edits related to benefit enhancement through the Next Generation (NG) Accountable Care Organization (ACO). |
| <b>SHORT NAME:</b>  | CLM_NEXT_GNRTN_ACO_IND_CD4                                                                                                                                                             |
| <b>LONG NAME:</b>   | CLM_NEXT_GNRTN_ACO_IND_CD4                                                                                                                                                             |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                   |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                      |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                    |
| <b>VALUES:</b>      | 0 = Base record (no enhancements)<br>1 = Population Based Payments (PBP)<br>2 = Telehealth<br>3 = Post Discharge Home Health Visits<br>4 = 3-Day SNF Waiver<br>5 = Capitation          |
| <b>COMMENT:</b>     | There are 5 of these ACO fields (CLM_NEXT_GNRTN_ACO_IND_CD1 - CLM_NEXT_GNRTN_ACO_IND_CD5).                                                                                             |

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## CLM\_NEXT\_GNRTN\_ACO\_IND\_CD5

|                     |                                                                                                                                                                                        |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code – Capitation                                                                                             |
| <b>DESCRIPTION:</b> | The field identifies the claims that qualify for specific claims processing edits related to benefit enhancement through the Next Generation (NG) Accountable Care Organization (ACO). |
| <b>SHORT NAME:</b>  | CLM_NEXT_GNRTN_ACO_IND_CD5                                                                                                                                                             |
| <b>LONG NAME:</b>   | CLM_NEXT_GNRTN_ACO_IND_CD5                                                                                                                                                             |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                   |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                      |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                    |
| <b>VALUES:</b>      | 0 = Base record (no enhancements)<br>1 = Population Based Payments (PBP)<br>2 = Telehealth<br>3 = Post Discharge Home Health Visits<br>4 = 3-Day SNF Waiver<br>5 = Capitation          |
| <b>COMMENT:</b>     | There are 5 of these ACO fields (CLM_NEXT_GNRTN_ACO_IND_CD1 - CLM_NEXT_GNRTN_ACO_IND_CD5).                                                                                             |

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## CLM\_NON\_UTLZTN\_DAYS\_CNT

**LABEL:** Claim Medicare Non Utilization Days Count

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

**SHORT NAME:** NUTILDAY

**LONG NAME:** CLM\_NON\_UTLZTN\_DAYS\_CNT

**TYPE:** NUM

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## CLM\_OP\_BENE\_PMT\_AMT

**LABEL:** Claim Outpatient Payment Amount to Beneficiary

**DESCRIPTION:** The amount paid, from the Medicare trust fund, to the beneficiary for the services reported on the outpatient claim.

**SHORT NAME:** BENEPMT

**LONG NAME:** CLM\_OP\_BENE\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## CLM\_OP\_ESRD\_MTHD\_CD

**LABEL:** Claim Outpatient End Stage Renal Disease (ESRD) Method of Reimbursement Code

**DESCRIPTION:** This variable contains the code denoting the method of reimbursement selected by the beneficiary receiving End Stage Renal Disease (ESRD) services for home dialysis (i.e. whether home supplies are purchased through a facility or from a supplier.)

**SHORT NAME:** CLM\_OP\_ESRD\_MTHD\_CD

**LONG NAME:** CLM\_OP\_ESRD\_MTHD\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** 0 = Not ESRD  
1 = Method 1 - Home supplies purchased through a facility  
2 = Method 2 - Home supplies purchased from a supplier

**COMMENT:** -

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## CLM\_OP\_PRVDR\_PMT\_AMT

**LABEL:** Claim Outpatient Provider Payment Amount

**DESCRIPTION:** The amount paid, from the Medicare trust fund, to the provider for the services reported on the outpatient claim.

**SHORT NAME:** PRVDRPMT

**LONG NAME:** CLM\_OP\_PRVDR\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## CLM\_OP\_TRANS\_TYPE\_CD

**LABEL:** Claim Outpatient transaction type

**DESCRIPTION:** The code derived by CMS based on the type of bill and provider number to identify the outpatient transaction type.

**SHORT NAME:** CLM\_OP\_TRANS\_TYPE\_CD

**LONG NAME:** CLM\_OP\_TRANS\_TYPE\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Outpatient Psychiatric Hospital
- B = Outpatient tuberculosis (TB) Hospital
- C = Outpatient General Care Hospital
- D = Outpatient Skilled Nursing Facility (SNF)
- E = Home Health Agency
- F = Comprehensive Health Care
- G = Clinical Rehab Agency
- H = Rural Health Clinic
- I = Satellite Dialysis Facility
- J = Limited Care Facility
- O = Christian Science SNF
- 1 = Psychiatric Hospital Facility
- 2 = TB Hospital Facility
- 3 = General Care Hospital
- 4 = Regular SNF
- Spaces = Home Health/Hospice

**COMMENT:** -

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## CLM\_PASS\_THRU\_PER\_DIEM\_AMT

**LABEL:** Claim Pass Thru Per Diem Amount

**DESCRIPTION:** Medicare establishes a daily payment amount to reimburse IPPS hospitals for certain “pass-through” expenses, such as capital-related costs, direct medical education costs, kidney acquisition costs for hospitals that are renal transplant centers, and bad debts. This variable is the daily payment rate for pass-through expenses. It is not included in the CLM\_PMT\_AMT field.

To determine the total of the pass-through payments for a hospitalization, this field should be multiplied by the claim Medicare utilization day count (CLM\_UTLZTN\_DAY\_CNT). Then, total Medicare payments for a hospitalization claim can be determined by summing this product and the CLM\_PMT\_AMT field.

**SHORT NAME:** PER\_DIEM

**LONG NAME:** CLM\_PASS\_THRU\_PER\_DIEM\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)), and also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see the list of MLN publications at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PMT\_AMT

**LABEL:** Claim (Medicare) Payment Amount

**DESCRIPTION:** The Medicare claim payment amount.

For hospital services, this amount does not include the claim pass-through per diem payments made by Medicare. To obtain the total amount paid by Medicare for the claim, the pass-through amount (which is the daily per diem amount) must be multiplied by the number of Medicare-covered days (i.e., multiply the CLM\_PASS\_THRU\_PER\_DIEM\_AMT by the CLM\_UTLZTN\_DAY\_CNT), and then added to the claim payment amount (this field).

For non-hospital services (SNF, home health, hospice, and hospital outpatient) and for other non-institutional services (Carrier and DME), this variable equals the total actual Medicare payment amount, and pass-through amounts do not apply.

For Part B non-institutional services (Carrier and DME), this variable equals the sum of all the line item-level Medicare payments (variable called the LINE\_NCH\_PMT\_AMT).

**SHORT NAME:** PMT\_AMT

**LONG NAME:** CLM\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_POA\_IND\_SW1

**LABEL:** Claim Diagnosis Code I Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW1

**LONG NAME:** CLM\_POA\_IND\_SW1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW2

**LABEL:** Claim Diagnosis Code II Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW2

**LONG NAME:** CLM\_POA\_IND\_SW2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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### CLM\_POA\_IND\_SW3

**LABEL:** Claim Diagnosis Code III Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW3

**LONG NAME:** CLM\_POA\_IND\_SW3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW4

**LABEL:** Claim Diagnosis Code IV Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW4

**LONG NAME:** CLM\_POA\_IND\_SW4

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW5

**LABEL:** Claim Diagnosis Code V Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW5

**LONG NAME:** CLM\_POA\_IND\_SW5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW6

**LABEL:** Claim Diagnosis Code VI Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW6

**LONG NAME:** CLM\_POA\_IND\_SW6

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW7

**LABEL:** Claim Diagnosis Code VII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW7

**LONG NAME:** CLM\_POA\_IND\_SW7

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW8

**LABEL:** Claim Diagnosis Code VIII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW8

**LONG NAME:** CLM\_POA\_IND\_SW8

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW9

**LABEL:** Claim Diagnosis Code IX Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW9

**LONG NAME:** CLM\_POA\_IND\_SW9

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW10

**LABEL:** Claim Diagnosis Code X Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW10

**LONG NAME:** CLM\_POA\_IND\_SW10

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW11

**LABEL:** Claim Diagnosis Code XI Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW11

**LONG NAME:** CLM\_POA\_IND\_SW11

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW12

**LABEL:** Claim Diagnosis Code XII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW12

**LONG NAME:** CLM\_POA\_IND\_SW12

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW13

**LABEL:** Claim Diagnosis Code XIII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW13

**LONG NAME:** CLM\_POA\_IND\_SW13

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW14

**LABEL:** Claim Diagnosis Code XIV Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW14

**LONG NAME:** CLM\_POA\_IND\_SW14

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW15

**LABEL:** Claim Diagnosis Code XV Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW15

**LONG NAME:** CLM\_POA\_IND\_SW15

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW16

**LABEL:** Claim Diagnosis Code XVI Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW16

**LONG NAME:** CLM\_POA\_IND\_SW16

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW17

**LABEL:** Claim Diagnosis Code XVII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW17

**LONG NAME:** CLM\_POA\_IND\_SW17

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW18

**LABEL:** Claim Diagnosis Code XVIII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW18

**LONG NAME:** CLM\_POA\_IND\_SW18

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW19

**LABEL:** Claim Diagnosis Code XIX Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW19

**LONG NAME:** CLM\_POA\_IND\_SW19

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW20

**LABEL:** Claim Diagnosis Code XX Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW20

**LONG NAME:** CLM\_POA\_IND\_SW20

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW21

**LABEL:** Claim Diagnosis Code XXI Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW21

**LONG NAME:** CLM\_POA\_IND\_SW21

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW22

**LABEL:** Claim Diagnosis Code XXII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW22

**LONG NAME:** CLM\_POA\_IND\_SW22

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW23

**LABEL:** Claim Diagnosis Code XXIII Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW23

**LONG NAME:** CLM\_POA\_IND\_SW23

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW24

**LABEL:** Claim Diagnosis Code XXIV Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW24

**LONG NAME:** CLM\_POA\_IND\_SW24

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_POA\_IND\_SW25

**LABEL:** Claim Diagnosis Code XXV Diagnosis Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:** CLM\_POA\_IND\_SW25

**LONG NAME:** CLM\_POA\_IND\_SW25

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

**COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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## CLM\_PPS\_CPTL\_DRG\_WT\_NUM

**LABEL:** Claim PPS Capital DRG Weight Number

**DESCRIPTION:** The number used to determine a transfer adjusted case mix index for capital, under the prospective payment system (PPS). The number is determined by multiplying the Diagnosis Related Group Code (DRG) weight times the discharge fraction.

Medicare assigns a weight to each DRG to reflect the average cost of caring for patients with the DRG compared to the average of all types of Medicare cases. This variable reflects the weight that is applied to the base payment amount.

The DRG weights in this variable reflect adjustments due to patient characteristics and factors related to the stay. For example, payments are reduced for certain short stay transfers or where patients are discharged to post-acute care. Therefore, for a given DRG, the weight in this field may vary.

**SHORT NAME:** DRGWTAMT

**LONG NAME:** CLM\_PPS\_CPTL\_DRG\_WT\_NUM

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" (see:

[http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm))

Also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PPS\_CPTL\_DSPRPRTNT\_SHR\_AMT

**LABEL:** Claim PPS Capital Disproportionate Share Amount

**DESCRIPTION:** The amount of disproportionate share (rate reflecting indigent population served) portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM\_TOT\_PPS\_CPTL\_AMT.

**SHORT NAME:** DISP\_SHR

**LONG NAME:** CLM\_PPS\_CPTL\_DSPRPRTNT\_SHR\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PPS\_CPTL\_EXCPTN\_AMT

**LABEL:** Claim PPS Capital Exception Amount

**DESCRIPTION:** 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.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM\_TOT\_PPS\_CPTL\_AMT.

**SHORT NAME:** CPTL\_EXP

**LONG NAME:** CLM\_PPS\_CPTL\_EXCPTN\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm))

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PPS\_CPTL\_FSP\_AMT

**LABEL:** Claim PPS Capital Federal Specific Portion (FSP) Amount

**DESCRIPTION:** The amount of the federal specific portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM\_TOT\_PPS\_CPTL\_AMT.

**SHORT NAME:** CPTL\_FSP

**LONG NAME:** CLM\_PPS\_CPTL\_FSP\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see:

[http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm))

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PPS\_CPTL\_IME\_AMT

**LABEL:** Claim PPS Capital Indirect Medical Education (IME) Amount

**DESCRIPTION:** The amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress to augment normal prospective payment system [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.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM\_TOT\_PPS\_CPTL\_AMT.

**SHORT NAME:** IME\_AMT

**LONG NAME:** CLM\_PPS\_CPTL\_IME\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PPS\_CPTL\_OUTLIER\_AMT

**LABEL:** Claim PPS Capital Outlier Amount

**DESCRIPTION:** The amount of the outlier portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM\_TOT\_PPS\_CPTL\_AMT.

**SHORT NAME:** CPTLOUTL

**LONG NAME:** CLM\_PPS\_CPTL\_OUTLIER\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" (see:

[http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm))

Also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PPS\_IND\_CD

**LABEL:** Claim PPS Indicator Code

**DESCRIPTION:** The code indicating whether or not:

- (1) the claim is from the prospective payment system (PPS), and/or
- (2) the beneficiary is a deemed insured MQGE (Medicare Qualified Government Employee)

**SHORT NAME:** PPS\_IND

**LONG NAME:** CLM\_PPS\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = Not a PPS bill  
2 = PPS bill; claim contains PPS indicator

**COMMENT:** -

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## CLM\_PPS\_OLD\_CPTL\_HLD\_HRMLS\_AMT

**LABEL:** Claim PPS Old Capital Hold Harmless Amount

**DESCRIPTION:** 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 hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.

**SHORT NAME:** HLDHRMLS

**LONG NAME:** CLM\_PPS\_OLD\_CPTL\_HLD\_HRMLS\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM\_TOT\_PPS\_CPTL\_AMT.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_PRCR\_RTRN\_CD

**LABEL:** Claim Pricer Return Code

**DESCRIPTION:** The code used to identify various prospective payment system (PPS) payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by the PRICER tool.

**SHORT NAME:** CLM\_PRCR\_RTRN\_CD

**LONG NAME:** CLM\_PRCR\_RTRN\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:** The meaning of the values varies by type of bill (TOB)

\*\*\*\*Inpatient Hospital Pricer Return Codes\*\*\*\*\*

\*\*\*\*\*TOB 11X\*\*\*\*\*

Inpatient Hospital Payment return codes:

00 = Paid normal DRG payment

01 = Paid as a day outlier (Note: day outlier no longer being paid as of 10/1/97)

02 = Paid as a cost outlier

03 = Transfer paid on a per diem basis up to and including the full DRG

05 = Transfer paid on a per diem basis up to and including the full DRG which also qualified for a cost outlier payment

06 = Provider refused cost outlier

10 = DRG is 209, 210, or 211 and post-acute transfer

12 = Post-acute transfer with specific DRGs. The following DRG's: 14, 113, 236, 263, 264, 429, 483

14 = Paid normal DRG payment with per diem days = or > GM ALOS

16 = Paid as a cost outlier with per diem days = or > GM ALOS

Inpatient Hospital Error return codes:

51 = No provider specific information found

52 = Invalid MSA# in provider file

53 = Waiver state - not calculated by PPS

54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438, 456, 457, 458

55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS

56 = Invalid length of stay

57 = Review code invalid (Not 00, 03, 06, 07, 09)

58 = Total charges not numeric  
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60  
62 = Invalid number of covered days  
65 = PAY-CODE not = A, B or C on provider specific file for capital  
67 = Cost outlier with LOS > covered days

\*\*\*Inpatient Rehab Facility (IRF) Pricer Return Codes\*\*\*

IRF Payment return codes:

00 = Paid normal CMG payment without outlier  
01 = Paid normal CMG payment with outlier  
02 = Transfer paid on a per diem basis without outlier  
03 = Transfer paid on a per diem basis with outlier  
04 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- without outlier  
05 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with outlier  
06 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- without outlier  
07 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with outlier  
10 = Paid normal CMG payment with penalty without outlier  
11 = Paid normal CMG payment with penalty with outlier  
12 = Transfer paid on a per diem basis with penalty without outlier  
13 = Transfer paid on a per diem basis with penalty with outlier  
14 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with penalty without outlier  
15 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with penalty with outlier  
16 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with penalty without outlier  
17 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with penalty with outlier

IRF Error return codes:

50 = Provider specific rate not numeric  
51 = Provider record terminated  
52 = Invalid wage index  
53 = Waiver state - not calculated by PPS  
54 = CMG on claim not found in table  
55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS  
56 = Invalid length of stay

57 = Provider specific rate zero when blended payment requested  
58 = Total covered charges not numeric  
59 = Provider specific record not found  
60 = MSA wage index record not found  
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60  
62 = Invalid number of covered days  
65 = Operating cost-to-charge ratio not numeric  
67 = Cost outlier with LOS > covered days or cost outlier threshold calculation  
72 = Invalid blend indicator (not 3 or 4)  
73 = Discharged before provider FY begin date  
74 = Provider FY begin date not in 2002

\*\*\*Long Term Care Hospital (LTCH) Pricer Return Codes\*\*\*

LTCH Payment return codes:

00 = Normal DRG payment without outlier  
01 = Normal DRG payment with outlier  
02 = Short stay payment without outlier  
03 = Short stay payment with outlier  
04 = Blend year 1 - 80% facility rate plus 20% normal DRG payment without outlier  
05 = Blend year 1 - 80% facility rate plus 20% normal DRG payment with outlier  
06 = Blend year 1 - 80% facility rate plus 20% short stay payment without outlier  
07 = Blend year 1 - 80% facility rate plus 20% short stay payment with outlier  
08 = Blend year 2 - 60% facility rate plus 40% normal DRG payment without outlier  
09 = Blend year 2 - 60% facility rate plus 40% normal DRG payment with outlier  
10 = Blend year 2 - 60% facility rate plus 40% short stay payment without outlier  
11 = Blend year 2 - 60% facility rate plus 40% short stay payment with outlier  
12 = Blend year 3 - 40% facility rate plus 60% normal DRG payment without outlier  
13 = Blend year 3 - 40% facility rate plus 60% normal DRG payment with outlier  
14 = Blend year 3 - 40% facility rate plus 60% short stay payment without outlier  
15 = Blend year 3 - 40% facility rate plus 60% short stay payment with outlier  
16 = Blend year 4 - 20% facility rate plus 80% normal DRG payment without outlier  
17 = Blend year 4 - 20% facility rate plus 80% normal DRG payment with outlier  
18 = Blend year 4 - 20% facility rate plus 80% short stay payment without outlier  
19 = Blend year 4 - 20% facility rate plus 80% short stay payment with outlier

LTCH Error return codes:

50 = Provider specific rate not numeric  
51 = Provider record terminated  
52 = Invalid wage index  
53 = Waiver state - not calculated by PPS  
54 = DRG on claim not found in table



55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS  
 56 = Invalid length of stay  
 57 = Provider specific rate zero when blended payment requested  
 58 = Total covered charges not numeric  
 59 = Provider specific record not found  
 60 = MSA wage index record not found  
 61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60  
 62 = Invalid number of covered days  
 65 = Operating cost-to-charge ratio not numeric  
 67 = Cost outlier with LOS > covered days or cost outlier threshold calculation  
 72 = Invalid blend indicator (not 1 thru 5)  
 73 = Discharged before provider FY begin date  
 74 = Provider FY begin date not in 2002

\*\*\*\*\*SNF Pricer Return Codes\*\*\*\*\*

\*\*\*\*\*TOB 21X\*\*\*\*\*

SNF Payment return codes:

00 = RUG III group rate returned SNF Error return codes:

20 = Bad RUG code  
 30 = Bad MSA code  
 40 = Thru date < July 1, 1998 or invalid  
 50 = Invalid Federal blend for that year  
 60 = Invalid Federal blend  
 61 = Federal blend = 0 and SNF thru date < January 1, 2000

\*\*\*\*\*Hospice Pricer Return Codes\*\*\*\*\*

\*\*\*\*\*TOB 81X or 82X\*\*\*\*\*

Hospice Payment Return Codes:

00 = Home rate returned Hospice Error Return Codes:

10 = Bad units  
 20 = Bad units2 < 8  
 30 = Bad MSA code  
 40 = Bad hospice wage index from MSA file  
 50 = Bad bene wage index from MSA file  
 51 = Bad provider number

\*\*\*\*\*Home Health Pricer Return Codes\*\*\*\*\*

\*\*\*\*\*TOB 32X or 33X, DOS 10/1/2000 and after\*\*\*\*\*

Home Health Payment Return Codes:

- 00 = Final payment where no outlier applies
- 01 = Final payment where outlier applies
- 03 = Initial percentage payment, 0%
- 04 = Initial percentage payment, 50%
- 05 = Initial percentage payment, 60%
- 06 = LUPA payment only
- 07 = Final payment, SCIC
- 08 = Final payment, SCIC with outlier
- 09 = Final payment, PEP
- 11 = Final payment, PEP with outlier
- 12 = Final payment, SCIC within PEP
- 13 = Final payment, SCIS within PEP with outlier

Home Health Error Return Codes:

- 10 = Invalid TOB
- 15 = Invalid PEP Days
- 16 = Invalid HRG Days, >60
- 20 = PEP indicator invalid
- 25 = Med review indicator invalid
- 30 = Invalid MSA code
- 35 = Invalid Initial Payment Indicator
- 40 = Dates < October 1, 2000 or invalid
- 70 = Invalid HRG Code
- 75 = No HRG present in 1st occurrence
- 80 = Invalid Revenue code
- 85 = No revenue code present on HH final claim/adjustment

\*\*\*\*\*Outpatient PPS Pricer Return Codes\*\*\*\*\*

Outpatient PPS Payment return codes:

- 01 = Line processed to payment
- 20 = Line processed but payment = 0 bene deductible = > adjusted payment

Outpatient PPS Error return codes:

- 30 = Missing, deleted or invalid APC
- 38 = Missing or invalid discount factor
- 40 = Invalid service indicator passed by the OCE
- 41 = Service indicator invalid for OPPS PRICER

42 = APC = '00000' or (packaging flag = 1 or 2)  
43 = Payment indicator not = to 1 or 5 thru 9  
44 = Service indicator = 'H' but payment indicator not = to 6  
45 = Packaging flag not = to 0  
46 = Line item denial/reject flag not = to 0 or line item denial/reject flag = to 1 and (APC not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325 or 0373 or 0374)) or line item action flag not = to 1  
47 = Line item action flag = 2 or 3  
48 = Payment adjustment flag not valid  
49 = Site of service flag not = to 0 or (APC 0033 is not on the claim and service indicator = 'P' or APC = 0322, 0325, 0373, 0374)  
50 = Wage index not located  
51 = Wage index equals zero  
52 = Provider specific file wage index reclassification code invalid or missing  
53 = Service from date not numeric or < 20000801  
54 = Service from date < provider effective date or service from date > provider termination date

\*\*\*End Stage Renal Disease (ESRD) Pricer Return Codes\*\*\*

ESRD Payment return codes:

00 = ESRD PPS payment calculated  
01 = ESRD facility rate > zero

ESRD Error return codes:

50 = ESRD facility rate not numeric  
52 = Provider type not = '40' or '41'  
53 = Special payment indicator not = '1' or blank  
54 = Date of birth not numeric or = zero  
55 = Patient weight not numeric or = zero  
56 = Patient height not numeric or = zero  
57 = Revenue center code not in range  
58 = Condition code not = '73' or '74' or blank  
60 = MSA wage adjusted rate record not found  
98 = Claim through date before 4/1/2005 or not numeric

**COMMENT:** The payment return code identifies the type of payment calculated by the PRICER software.

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## CLM\_RLT\_COND\_CD

**LABEL:** Claim Related Condition Code

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

**SHORT NAME:** RLT\_COND

**LONG NAME:** CLM\_RLT\_COND\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

|              |                                                                                               |
|--------------|-----------------------------------------------------------------------------------------------|
| 01 THRU 16 = | Insurance related                                                                             |
| 17 THRU 30 = | Special condition                                                                             |
| 31 THRU 35 = | Student status codes which are required when a patient is a dependent child over 18 years old |
| 36 THRU 45 = | Accommodation                                                                                 |
| 46 THRU 54 = | CHAMPUS information                                                                           |
| 55 THRU 59 = | Skilled nursing facility                                                                      |
| 60 THRU 70 = | Prospective payment                                                                           |
| 71 THRU 99 = | Renal dialysis setting                                                                        |
| A0 THRU B9 = | Special program codes                                                                         |
| C0 THRU C9 = | QIO approval services                                                                         |
| D0 THRU W0 = | Change conditions                                                                             |

=====

- |      |                                                                                                                                                                                             |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 01 = | Military service related - Medical condition incurred during military service.                                                                                                              |
| 02 = | Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/events resulting from employment.                                       |
| 03 = | Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.                   |
| 04 = | Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Hospital must also expect to receive payment from HMO.                                         |
| 05 = | Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.                  |
| 06 = | ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.                                                                                                    |
| 07 = | Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement. |
| 08 = | Beneficiary would not provide information concerning other insurance coverage.                                                                                                              |

- 09 = Neither patient nor spouse is employed - Code indicates that in response to development questions, the patient and spouse have denied employment.
- 10 = Patient and/or spouse is employed but no EGHP coverage exists or other employer sponsored/provided health insurance covering patient.
- 11 = The disabled beneficiary and/or family member has no group coverage from a LGHP or other employer sponsored/provided health insurance covering patient.
- 12 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 13 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 14 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 15 = Clean claim. Delayed in CMS's processing system.
- 16 = SNF transition exemption - An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
- 17 = Patient is homeless.
- 18 = Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name.
- 19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.
- 20 = Beneficiary requested billing - Provider realizes the services on this bill are at a non-covered level of care or otherwise excluded from coverage, but the bene has requested formal determination
- 21 = Billing for denial notice - The SNF or HHA realizes services are at a non-covered level of care or excluded, but requests a Medicare denial in order to bill Medicaid or other insurer
- 22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy
- 23 = Home caregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug
- 24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services
- 25 = Reserved for national assignment
- 26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility
- 27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only).
- 28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees.
- 29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees

- 30 = Qualifying Clinical Trials - Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
- 31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
- 32 = Patient is student (cooperative/work study program)
- 33 = Patient is student (full time-night)- Patient declares that he or she is enrolled as a full time night student.
- 34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
- 36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
- 37 = Ward accommodation at patient's request - Patient is assigned to ward accommodations at patient's request.
- 38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
- 39 = Private room medically necessary - Patient needed a private room for medical reasons.
- 40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.
- 41 = Partial hospitalization services. For OP services, this includes a variety of psychiatric programs.
- 42 = Continuing Care Not Related to Inpatient Admission - continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services. (eff. 10/01)
- 43 = Continuing Care Not Provided Within Prescribed Post-discharge Window - continuing care was related to the inpatient admission but the prescribed care was not provided within the post-discharge window.(eff. 10/01)
- 44 = Inpatient Admission Changed to Outpatient - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. (eff. 4/1/04)
- 45 = Reserved for national assignment.
- 46 = Non-availability statement on file for TRICARE claim for nonemergency IP care for TRICARE bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
- 47 = Reserved for TRICARE.
- 48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs). Claims submitted by TRICARE.
- 49 = Product Replacement within Product Lifecycle - replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)
- 50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006)

- 51 = Reserved for national assignment.
- 52 = Reserved for national assignment.
- 53 = Reserved for national assignment.
- 54 = Reserved for national assignment.
- 55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
- 56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
- 57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
- 58 = Terminated Managed Care Organization Enrollee - patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.
- 59 = Non-primary ESRD Facility - ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. (eff.10/2004)
- 60 = Operating cost day outlier - PRICER indicates this bill is length of stay outlier (PPS)
- 61 = Operating cost outlier - PRICER indicates this bill is a cost outlier (PPS)
- 62 = PIP bill - This bill is a periodic interim payment bill.
- 63 = Payer Only Code - Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or patient in State or local custody meeting requirements of 42 CFR 411.4(b)
- 64 = Other than clean claim - The claim is not a 'clean claim'
- 65 = Non-PPS bill - The bill is not a prospective payment system bill.
- 66 = Hospital Does Not Wish Cost Outlier Payment - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)
- 67 = Beneficiary elects not to use Lifetime Reserve (LTR) days
- 68 = Beneficiary elects to use LTR days
- 69 = IME/DGME/N&A Payment Only - providers request for request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health).
- 70 = Self-administered Epoetin (EPO) - Billing is for a home dialysis patient who self-administers EPO.
- 71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
- 72 = Self-care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
- 73 = Self-care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
- 74 = Home - Billing is for a patient who received dialysis services at home.
- 75 = Home dialysis patient using a dialysis machine that was purchased under the 100% program.

- 76 = Back-up in facility dialysis - Billing is for a patient who received dialysis services in a back-up facility.
- 77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by the primary payer as payment in full - no Medicare payment is due.
- 78 = New coverage not implemented by HMO, indicates newly covered service under Medicare for which HMO does not pay.
- 79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.
- 80 = Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. (eff. 4/4/05)
- 81-99 = Reserved for state assignment.
- A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)
- A1 = EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code.
- A2 = Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped.
- A3 = Special federal funding - Designed for uniform use by state uniform billing committees. Special program indicator code
- A4 = Family planning - Designed for uniform use by state uniform billing committees. Special program indicator code
- A5 = Disability - Designed for uniform use by state uniform billing committees.
- A6 = PPV/Medicare - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.
- A7 = Induced abortion to avoid danger to woman's life.
- A8 = Induced abortion - Victim of rape/incest. Special program indicator code
- A9 = Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
- AA = Abortion Performed due to Rape (eff. 10/1/02)
- AB = Abortion Performed due to Incest (eff. 10/1/02)
- AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality (eff. 10/1/02)
- AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or exacerbated by the Pregnancy itself (eff. 10/1/02)
- AE = Abortion Performed due to physical health of mother that is not life endangering (eff. 10/1/02)
- AF = Abortion performed due to emotional/psychological health of mother (eff. 10/1/02)
- AG = Abortion performed due to social economic reasons (eff. 10/1/02)
- AH = Elective Abortion (eff. 10/1/02)
- AI = Sterilization (eff. 10/1/02)



- AJ = Payer Responsible for copayment (4/1/03)
- AK = Air Ambulance Required - For ambulance claims. Time needed to transport poses a threat. (eff. 10/16/03)
- AL = Specialized Treatment/bed Unavailable - For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility. (eff. 10/16/03)
- AM = Non-emergency Medically Necessary Stretcher Transport Required - For ambulance claims. Non-emergency medically necessary stretcher transport required. (eff. 10/16/03)
- AN = Preadmission Screening Not Required – person meets the criteria for an exemption from preadmission screening. (eff. 1/1/04)
- B0 = Medicare Coordinated Care Demonstration Program - patient is a participant in a Medicare Coordinated Care Demonstration (eff. 10/01)
- B1 = Beneficiary ineligible for demonstration program (eff. 1/02).
- B2 = Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule
- B3 = Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/03)
- B4 = Admission Unrelated to Discharge – Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.
- B5 = Special program indicator Reserved for national assignment.
- B6 = Special program indicator Reserved for national assignment.
- B7 = Special program indicator Reserved for national assignment.
- B8 = Special program indicator Reserved for national assignment.
- B9 = Special program indicator Reserved for national assignment.
- C0 = Reserved for national assignment.
- C1 = Approved as billed - Claim has been reviewed by the QIO and has been fully approved including any outlier.
- C2 = QIO approval indicator services. NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C3 = Partial approval - some portion (days or services). From/Through dates of the approved portion of the stay are shown as code “M0” in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code “77” in FL 36 or code “46” in FL 39-41).
- C4 = Admission denied - The patient’s need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary.
- C5 = Post-payment review applicable - Any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
- C6 = Preadmission/Pre-procedure authorization - The QIO authorized this admission/procedure but has not reviewed the services provided.
- C7 = Extended authorization - The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
- C8 = Reserved for national assignment. QIO approval indicator services

- C9 = Reserved for national assignment. QIO approval indicator services
- D0 = Changes to service dates.
- D1 = Changes in charges.
- D2 = Changes in revenue codes/HCPCS/HIPPS Rate Code - Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
- D3 = Second or subsequent interim PPS bill.
- D4 = Change in ICD-9-CM diagnosis and/or procedure code
- D5 = Cancel only to correct a beneficiary claim account number (HICN) or provider identification number.
- D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill).
- D7 = Change to make Medicare the secondary payer.
- D8 = Change to make Medicare the primary payer.
- D9 = Any other change.
- DR = Disaster Relief (eff. 10/2005) - Code used to facilitate claims processing and track services/items provided to victims of disasters.
- E0 = Change in patient status.
- EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study
- G0 = Distinct Medical Visit - Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits.
- H0 = Delayed Filing, Statement of Intent Submitted - statement of intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
- M0 = All-inclusive rate for outpatient services. Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.
- M1 = Roster billed influenza virus vaccine or pneumococcal pneumonia vaccine (PPV).
- M2 = HHA Payment Significantly Exceeds Total Charges - Used when payment to an HHA is significantly in excess of covered billed charges.
- MA = GI Bleed.
- MB = Pneumonia.
- MC = Pericarditis.
- MD = Myelodysplastic Syndrome.
- ME = Hereditary Hemolytic and Sickle Cell Anemia.
- MF = Monoclonal Gammopathy.
- W0 = United Mine Workers of America (UMWA) SNF demonstration indicator
- XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/07)

**COMMENT:** -

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## CLM\_RLT\_OCRNC\_CD

**LABEL:** Claim Related Occurrence Code

**DESCRIPTION:** The code that identifies a significant event relating to an institutional claim that may affect payer processing.

These codes are associated with a specific date (the claim related occurrence date).

**SHORT NAME:** OCRNC\_CD

**LONG NAME:** CLM\_RLT\_OCRNC\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

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

=====

- 01 = Auto accident - The date of an auto accident.
- 02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
- 03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
- 04 = Accident/employment related - The date of an accident relating to the patient's employment.
- 05 = Other accident - The date of an accident not described by the codes 01 thru 04.
- 06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
- 07 = Reserved for national assignment.
- 08 = Reserved for national assignment.

- 11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
- 12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.
- 13 = Reserved for national assignment.
- 14 = Reserved for national assignment.
- 15 = Reserved for national assignment.
- 16 = Reserved for national assignment.
- 17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed.
- 18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.
- 19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
- 20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
- 21 = UR notice received - Code indicating the date of receipt by the hospital & SNF of the UR committee's finding that the admission or future stay was not medically necessary.
- 22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
- 23 = Cancellation of Hospice benefits - The date the RHHI cancelled the hospice benefit. (eff. 10/00). NOTE: this will be different than the revocation of the hospice benefit by beneficiaries.
- 24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.
- 25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.
- 26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.

- 27 = Date of Hospice Certification or Re-Certification -- code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/01)
- 27 = Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed. (Obsolete) not used by hospital unless owner of facility
- 28 = Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed. Not used by hospital unless owner of facility
- 29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy. Not used by hospital unless owner of facility
- 30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed. Not used by hospital unless owner of facility
- 31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.
- 32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.
- 33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
- 34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
- 35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
- 36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.
- 37 = The date of discharge for the IP hospital stay when patient received a non-covered transplant procedure - Hospital is billing for immunosuppressive drugs.
- 38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.

- 39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.
- 40 = Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
- 41 = Date of First Test for Pre-admission Testing - The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/01)
- 42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Date patient revoked hospice election.
- 43 = Scheduled Date of Canceled Surgery - date which ambulatory surgery was scheduled. (eff. 9/01)
- 44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.
- 45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.
- 46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
- 47 = Date Cost Outlier Status Begins - code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)
- 48 = Payer code - Code reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers will not report it.
- 49 = Payer code - Code reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers will not report it.
- 50-69 = Reserved for state assignment
- A1 = Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried.
- A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force.
- A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A.

- B1 = Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried.
- B2 = Effective date, Insured B policy - A code indicating the first date insurance is in force.
- B3 = Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B.
- C1 = Birthdate, Insured C - The birthdate of the individual in whose name the insurance is carried.
- C2 = Effective date, Insured C policy - A code indicating the first date insurance is in force.
- C3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer C.

**COMMENT:** -

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## CLM\_RLT\_OCRNC\_DT

**LABEL:** Claim Related Occurrence Date

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

The date for the event that appears in the claim related occurrence code field.

**SHORT NAME:** OCRNCDT

**LONG NAME:** CLM\_RLT\_OCRNC\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## CLM\_SITE\_NTRL\_PYMT\_CST\_AMT

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Site Neutral Payment Based on Cost Amount                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>DESCRIPTION:</b> | Under the Long Term Care Hospital (LTCH) prospective payment system (PPS), the payment amount based on estimated cost of the case.                                                                                                                                                                                                                                                                                                                      |
| <b>SHORT NAME:</b>  | CLM_SITE_NTRL_PYMT_CST_AMT                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>LONG NAME:</b>   | CLM_SITE_NTRL_PYMT_CST_AMT                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>COMMENT:</b>     | <p>Applies only to Inpatient (LTCH) claims. This field is new in October 2015.</p> <p>For a LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.</p> |

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## CLM\_SITE\_NTRL\_PYMT\_IPPS\_AMT

**LABEL:** Claim Site Neutral Payment Based on Inpatient Prospective Payment System (IPPS) Amounts

**DESCRIPTION:** Under the Long Term Care Hospital (LTCH) prospective payment system (PPS), the payment amount based on the inpatient prospective payment system (IPPS) comparable amount. This amount does not include any applicable outlier payment amount.

**SHORT NAME:** CLM\_SITE\_NTRL\_PYMT\_IPPS\_AMT

**LONG NAME:** CLM\_SITE\_NTRL\_PYMT\_IPPS\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Applies only to Inpatient (LTCH) claims. This field is new in October 2015.

For a LTCH PPS claim, only one of four fields will be populated (CLM\_SITE\_NTRL\_PYMT\_CST\_AMT, CLM\_SITE\_NTRL\_PYMT\_IPPS\_AMT, CLM\_FULL\_STD\_PYMT\_AMT, or CLM\_SS\_OUTLIER\_STD\_PYMT\_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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## CLM\_SPAN\_CD

**LABEL:** Claim Occurrence Span Code

**DESCRIPTION:** The code that identifies a significant event relating to an institutional claim that may affect payer processing.

These codes are claim-related occurrences that are related to a time period span of dates (variables called the CLM\_SPAN\_FROM\_DT and CLM\_SPAN\_THRU\_DT).

**SHORT NAME:** SPAN\_CD

**LONG NAME:** CLM\_SPAN\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

|      |                                                                                                                                                                                                                                              |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 70 = | Payer use only, the non-utilization from/thru dates for PPS-inlier stay where bene had exhausted all full/coinsurance days, but covered on cost report. SNF qualifying hospital stay from/thru dates                                         |
| 71 = | Hospital prior stay dates – the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.                                                                                                            |
| 72 = | First/last visit – the dates of the first and last visits occurring in this billing period if the dates are different from those in the statement covers period.                                                                             |
| 73 = | Benefit eligibility period – the inclusive dates during which CHAMPUS medical benefits are available to a sponsor's bene as shown on the bene's ID card.                                                                                     |
| 74 = | Non-covered level of care – The from/thru dates of a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span code 76, 77, or 79.                                              |
| 75 = | The from/thru dates of SNF level of care during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. Not applicable to swing bed cases. PPS hospitals use in day outlier cases only.         |
| 76 = | Patient liability – From/thru dates of period of non-covered care for which hospital may charge bene. The FI or PRO must have approved such charges in advance. Patient must be notified in writing 3 days prior to non-covered period       |
| 77 = | Provider liability (utilization charged) – The from/thru dates of period of non-covered care for which the provider is liable. Applies to provider liability where bene is charged with utilization and is liable for deductible/coinsurance |
| 78 = | SNF prior stay dates – The from/thru dates of any SNF stay that ended within 60 days of this hospital or SNF admission.                                                                                                                      |

79 = Provider Liability (non-utilization) (Payer code) – from/thru dates of period of non-covered care where bene is not charged with utilization, deductible, or coinsurance; and provider is liable. Non-covered period of care due to lack of medical necessity.

80-99 = Reserved for state assignment

M0 = PRO/UR approved stay dates – the first and last days that were approved where not all of the stay was approved.

M1 = Provider Liability-No Utilization – from/thru dates of a period of non-covered care that is denied due to lack of medical necessity or custodial care for which the provider is liable. (eff. 10/01)

M2 = Dates of Inpatient Respite Care – from/thru dates of a period of inpatient respite care for hospice patients. (eff. 10/00)

**COMMENT:** -

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## CLM\_SPAN\_FROM\_DT

**LABEL:** Claim Occurrence Span From Date

**DESCRIPTION:** The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

The first date associated with the claim occurrence span code (variable called the CLM\_SPAN\_CD).

**SHORT NAME:** SPANFROM

**LONG NAME:** CLM\_SPAN\_FROM\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## CLM\_SPAN\_THRU\_DT

**LABEL:** Claim Occurrence Span Through Date

**DESCRIPTION:** The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

The last date associated with the claim occurrence span code (variable called the CLM\_SPAN\_CD).

**SHORT NAME:** SPANTHRU

**LONG NAME:** CLM\_SPAN\_THRU\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## CLM\_SRC\_IP\_ADMSN\_CD

**LABEL:** Claim Source Inpatient Admission Code

**DESCRIPTION:** The code indicating the source of the referral for the admission or visit.

**SHORT NAME:** SRC\_ADMS

**LONG NAME:** CLM\_SRC\_IP\_ADMSN\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** For Inpatient/SNF Claims:

- 0 = ANOMALY: invalid value, if present, translate to '9'
- 1 = Non-Health Care Facility Point of Origin (Physician Referral) – The patient was admitted to this facility upon an order of a physician.
- 2 = Clinic referral – The patient was admitted upon the recommendation of this facility's clinic physician.
- 3 = HMO referral - Reserved for national Prior to 3/08, HMO referral – The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
- 4 = Transfer from hospital (Different Facility) – The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.
- 5 = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) – The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
- 6 = Transfer from another health care facility – The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.
- 7 = Emergency room – The patient was admitted to this facility after receiving services in this facility's emergency room department (CMS discontinued this code 07/2010, although a small number of claims with this code appear after that time).

- 8 = Court/law enforcement – The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
- 9 = Information not available – The means by which the patient was admitted is not known.
- A = Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
- B = Transfer from Another Home Health Agency – The patient was admitted to this home health agency as a transfer from another home health agency.  
(Discontinued July 1, 2010- See Condition Code 47)
- C = Readmission to Same Home Health Agency – The patient was readmitted to this home health agency within the same home health episode period.  
(Discontinued July 1, 2010)
- D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer – The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
- E = Transfer from Ambulatory Surgical Center
- F = Transfer from hospice and is under a hospice plan of care or enrolled in hospice program

For Newborn Type of Admission

- 1 = Normal delivery – A baby delivered without complications.
- 2 = Premature delivery – A baby delivered with time and/or weight factors qualifying it for premature status.
- 3 = Sick baby – A baby delivered with medical complications, other than those relating to premature status.
- 4 = Extramural birth – A baby delivered in a nonsterile environment.
- 5 = Reserved for national assignment.
- 6 = Reserved for national assignment.
- 7 = Reserved for national assignment.
- 8 = Reserved for national assignment.
- 9 = Information not available.

**COMMENT:** -

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## CLM\_SRVC\_CLSFCTN\_TYPE\_CD

**LABEL:** Claim Service Classification Type Code

**DESCRIPTION:** The type of service provided to the beneficiary.

**SHORT NAME:** TYPESRVC

**LONG NAME:** CLM\_SRVC\_CLSFCTN\_TYPE\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** For facility type code 1 thru 6, and 9:

- 1 = Inpatient
- 2 = Inpatient or Home Health (covered on Part B)
- 3 = Outpatient (or HHA - covered on Part A)
- 4 = Other (Part B) -- (Includes HHA medical and other health services, e.g., SNF osteoporosis-injectable drugs)
- 5 = Intermediate care - level I
- 6 = Intermediate care - level II
- 7 = Subacute Inpatient (revenue code 019X required) (formerly Intermediate care - level III)
- 8 = Swing bed

For facility type code 7 (clinics):

- 1 = Rural Health Clinic (RHC)
- 2 = Hospital based or independent renal dialysis facility
- 3 = Free-standing provider based federally qualified health center (FQHC)
- 4 = Other Rehabilitation Facility (ORF)
- 5 = Comprehensive Rehabilitation Center (CORF)
- 6 = Community Mental Health Center (CMHC)
- 7 = Federally Qualified Health Center (FQHC)

For facility type code 8 (special facility):

- 1 = Hospice (non-hospital based)
- 2 = Hospice (hospital based)
- 3 = Ambulatory surgical center (ASC) in hospital outpatient department
- 4 = Freestanding birthing center
- 5 = Critical Access Hospital - Outpatient Services

**COMMENT:** This field, in combination with the facility type code (variable called CLM\_FAC\_TYPE\_CD) indicates the "type of bill" for an institutional claim. Many different types of services

can be billed on a Part A or Part B institutional claim, and knowing the type of bill helps to distinguish them. The type of bill is the concatenation of two variables: the facility type (CLM\_FAC\_TYPE\_CD) and the service classification type code (CLM\_SRVC\_CLSFCTN\_TYPE\_CD).

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## CLM\_SRVC\_FAC\_ZIP\_CD

**LABEL:** Claim service facility ZIP code (where service was provided)

**DESCRIPTION:** ZIP code where service was provided, as indicated on the claim.

**SHORT NAME:** CLM\_SRVC\_FAC\_ZIP\_CD

**LONG NAME:** CLM\_SRVC\_FAC\_ZIP\_CD

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** NCH

**VALUES:** XXXXXXXXX

**COMMENT:** -

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## CLM\_SS\_OUTLIER\_STD\_PYMT\_AMT

**LABEL:** Claim Short Stay Outlier (SSO) Standard Payment Amount

**DESCRIPTION:** This variable is the standard payment amount for long-term care hospitals (LTCH) under the Medicare prospective payment system (PPS), which is based on the MS-LTC-DRG with the short stay outlier (SSO) adjustment.

This amount does not include any other applicable outlier payment amount.

**SHORT NAME:** CLM\_SS\_OUTLIER\_STD\_PYMT\_AMT

**LONG NAME:** CLM\_SS\_OUTLIER\_STD\_PYMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Applies only to Inpatient (LTCH) claims. This field is new in October 2015.

For a LTCH PPS claim, only one of four fields will be populated (CLM\_SITE\_NTRL\_PYMT\_CST\_AMT, CLM\_SITE\_NTRL\_PYMT\_IPPS\_AMT, CLM\_FULL\_STD\_PYMT\_AMT, or CLM\_SS\_OUTLIER\_STD\_PYMT\_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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## CLM\_THRU\_DT

**LABEL:** Claim Through Date

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

**SHORT NAME:** THRU\_DT

**LONG NAME:** CLM\_THRU\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For Home Health prospective payment system (PPS) claims, the 'from' date and the 'thru' date on the RAP (Request for Anticipated Payment) initial claim match.

The "thru" date on the claim may not always represent the last date of services, particularly for Home Health or Hospice care. To obtain the date corresponding with the cessation of services (or discharge date) use the discharge date from the claim (variable called NCH\_BENE\_DSCHRG\_DT; note - this variable is not available for Home Health claims).

For Part B non-institutional (Carrier and DME) services, this variable corresponds with the latest of any of the line-item level dates (i.e., in the Line File, it is the last CLM\_THRU\_DT for any line on the claim). It is almost always the same as the CLM\_FROM\_DT; exception is for DME claims - where some services are billed in advance.

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## CLM\_TOT\_CHRG\_AMT

**LABEL:** Claim Total Charge Amount

**DESCRIPTION:** The total charges for all services included on the institutional claim.

This field is redundant with revenue center code 0001/total charges.

**SHORT NAME:** TOT\_CHRG

**LONG NAME:** CLM\_TOT\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## CLM\_TOT\_PPS\_CPTL\_AMT

**LABEL:** Claim Total PPS Capital Amount

**DESCRIPTION:** The total amount that is payable for capital for the prospective payment system (PPS) 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.

**SHORT NAME:** PPS\_CPTL

**LONG NAME:** CLM\_TOT\_PPS\_CPTL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## CLM\_TRTMT\_AUTHRZTN\_NUM

**LABEL:** Claim Treatment Authorization Number

**DESCRIPTION:** The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer.

**SHORT NAME:** CLM\_TRTMT\_AUTHRZTN\_NUM

**LONG NAME:** CLM\_TRTMT\_AUTHRZTN\_NUM

**TYPE:** CHAR

**LENGTH:** 18

**SOURCE:** NCH

**VALUES:** XXXXXXXX

**COMMENT:** This number is used by the fiscal intermediary and the Peer Review Organization.

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## CLM\_UNCOMP\_D\_CARE\_PMT\_AMT

**LABEL:** Claim Uncompensated Care Payment Amount

**DESCRIPTION:** This field identifies the payment for disproportionate share hospitals (DSH). It represents the uncompensated care amount of the payment.

**SHORT NAME:** CLM\_UNCOMP\_D\_CARE\_PMT\_AMT

**LONG NAME:** CLM\_UNCOMP\_D\_CARE\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field applies only to inpatient claims.

These payments were authorized as part of Section 3133 of the Affordable Care Act (ACA).

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## CLM\_UTLZTN\_DAY\_CNT

**LABEL:** Claim Medicare Utilization Day Count

**DESCRIPTION:** 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.

It excludes any days classified as non-covered, leave of absence days, and the day of discharge or death.

**SHORT NAME:** UTIL\_DAY

**LONG NAME:** CLM\_UTLZTN\_DAY\_CNT

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## CLM\_VAL\_AMT

**LABEL:** Claim Value Amount

**DESCRIPTION:** The amount related to the condition identified in the claim value code (variable called CLM\_VAL\_CD) which was used by the intermediary to process the institutional claim.

**SHORT NAME:** VAL\_AMT

**LONG NAME:** CLM\_VAL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## CLM\_VAL\_CD

**LABEL:** Claim Value Code

**DESCRIPTION:** The code indicating a monetary condition which was used by the intermediary to process an institutional claim.

The associated monetary value is in the claim value amount field (CLM\_VAL\_AMT).

**SHORT NAME:** VAL\_CD

**LONG NAME:** CLM\_VAL\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

|      |                                                                                                                                                                         |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 01 = | Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.                                                               |
| 02 = | Hospital Has No Semi-Private Rooms - Entering this code requires \$0.00 amount.                                                                                         |
| 03 = | Reserved for national assignment.                                                                                                                                       |
| 04 = | Inpatient professional component charges which are combined billed - For use only by some all-inclusive rate hospitals.                                                 |
| 05 = | Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.       |
| 06 = | Medicare blood deductible - Total cash blood deductible (Part A blood deductible).                                                                                      |
| 07 = | Medicare cash deductible reserved for national assignment.                                                                                                              |
| 08 = | Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission.                                              |
| 09 = | Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission.                                                    |
| 10 = | Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years. |
| 11 = | Medicare Part A coinsurance amount in the second calendar year -                                                                                                        |

Coinsurance amount charged in the year of discharge where the bill spans two calendar years

- 12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
- 13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
- 15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 16 = That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
- 17 = Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry).
- 18 = Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry).
- 19 = Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry).
- 20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

- 21 = Catastrophic - Medicaid - Eligibility requirements to be determined at state level.
- 22 = Surplus - Medicaid - Eligibility requirements to be determined at state level.
- 23 = Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level.
- 24 = Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level.
- 25 = Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).
- 26 = Prescription Drugs Offset to Patient (Payment Amount - Hearing and Ear Services) Hearing and ear services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement covers period).
- 27 = Offset to the Patient (Payment Amount - Vision and Eye Services) - Vision and eye services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 28 = Offset to the Patient (Payment Amount - Dental Services) - Dental services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 29 = Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropractic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 31 = Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for non-covered accommodations, diagnostic procedures or treatments.
- 32 = Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination. (eff. 4/1/2003)
- 33 = Offset to the Patient Payment Amount (Podiatric Services) -- Podiatric services paid out of a long-term care facility resident/patient's funds in the billing period submitted.

- 34 = Offset to the Patient Payment Amount (Medical Services) -- Other medical services paid out of a long-term care facility resident/ patient's funds in the billing period submitted.
- 35 = Offset to the Patient Payment Amount (Health Insurance Premiums) -- Other medical services paid out of a long-term care facility resident/ patient's funds in the billing period submitted.
- 37 = Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient.
- 38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.
- 39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient.
- 40 = New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO. (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
- 41 = Amount is that portion of a payment from higher priority BL program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 43 = Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.
- 44 = Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due.
- 45 = Accident Hour - The hour the accident occurred that necessitated medical treatment.

- 46 = Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care.
- 47 = Any liability insurance - Amount is that portion from a higher priority liability insurance made on behalf of Medicare bene the provider is applying to Medicare covered services on this bill.
- 48 = Hemoglobin reading - The patient's most recent hemoglobin reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during the billing cycle.
- 49 = Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing cycle.
- 50 = Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.
- 51 = Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
- 52 = Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.
- 53 = Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.
- 54 = New birth weight in grams - Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of '4' and on other claims as required by law.
- 55 = Eligibility Threshold for Charity Care - code identifies the corresponding value amount at which a health care facility determines the eligibility threshold of charity care.
- 56 = Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
- 57 = Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.
- 58 = Arterial blood gas - Arterial blood gas value at beginning of each



reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

59 = Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

60 = HHA branch MSA - MSA in which HHA branch is located.

61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.

NOTE: HHA claims with a thru date on or before 12/31/05, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/05, the value code amount field reflects the CBSA code.

62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

66 = Medicare Spend-down Amount -- The dollar amount that was used to meet the recipient's spend-down liability for this claim.

67 = Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home).

68 = EPO drug - Number of units of EPO administered relating to the billing period.

69 = State charity Care Percent

- 70 = Interest amount - (Providers do not report this.) Report the amount applied to this bill.
- 71 = Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
- 72 = Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.
- 73 = Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.
- 74 = Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.
- 75 = Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.
- 76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)
- 77 = New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary. (eff. 4/1/03, under Inpatient PPS)
- 78 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.
- 79 = Payer code - This code is set aside for payer use only. Providers do not report these codes.
- 80 = Covered Days
- 81 = Non-Covered Days
- 82 = Coinsurance Days
- 83 = Lifetime Reserve Days

84-99 = Reserved for state assignment.

- A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)
- A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (eff. 10/93) - Prior value 07
- A2 = Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer.
- A3 = Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.
- A4 = Self-administered drugs administered in an emergency situation - Ordinarily the only non-covered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma.
- A5 = Covered self-administered drugs -- The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to the patient.
- A6 = Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.
- A7 = Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- A8 = Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.
- A9 = Patient Height - Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
- AA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).

- AB = Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).
- B1 = Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
- B2 = Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer.
- B3 = Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
- B7 = Copayment B -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- BA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
- BB = Other Assessments or Allowances (Payer B) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).
- C1 = Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
- C2 = Coinsurance Payer C - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer.
- C3 = Estimated Responsibility Payer C - The stop/
- C7 = Copayment C -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
- CB = Other Assessments or Allowances (Payer C) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

- D3 = Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.
- D4 = Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 10/1/07)
- D5 = Result of last Kt/V
- FC = Patient Prior Payments
- FD = Reserved for national assignment
- G8 = Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08)
- XX = Total Charge Amount for all Part A visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part A visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the NCHMQA system (eff. 10/31/01 with HHPPS).
- XY = Total Charge Amount for all Part B visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part B visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the NCHMQA system (eff. 10/31/01 with HHPPS).
- XZ = Total Charge Amount for all Part B non-visit charges on the RIC 'U' claims - for Home Health claims containing both Part A & Part B services, this code identifies the total charge amount for the Part B non-visit charges. Code created internally in the NCHMQA system (eff. 10/31/01 with HHPPS).
- Y1 = Part A demo payment - Portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
- Y2 = Part B demo payment - Portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.

- Y3 = Part B coinsurance - Amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
- Y4 = Conventional Provider Payment Amount for Non-Demonstration Claims - This the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.

**COMMENT:** -

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## CLM\_VBP\_ADJSTMT\_PCT

**LABEL:** Claim VBP Adjustment Percent

**DESCRIPTION:** Under the Hospital Value Based Purchasing (HVBP) program, an adjustment is made to the base operating DRG amount for certain Inpatient Prospective Payment System (IPPS) hospitals - based on their Total Performance Score (TPS).

**SHORT NAME:** CLM\_VBP\_ADJSTMT\_PCT

**LONG NAME:** CLM\_VBP\_ADJSTMT\_PCT

**TYPE:** NUM

**LENGTH:** 15

**SOURCE:** NCH

**VALUES:** X.XX

**COMMENT:** This initiative began in 4th Quarter of 2013 (i.e., beginning of Federal fiscal year 14 [FY14]).

This field was new in 2013, and is null/missing for all previous years.

The HVBP applies only to subsection (d) IPPS hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (see CLM\_VBP\_PRTCPNT\_IND\_CD). This percentage reduction is applied to the base operating DRG amount, depending on their TPS (which is the Value Based Purchasing Score), as required by the Affordable Care Act (ACA). The percentages change each FY.

Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

The actual dollar amount of the adjustment that applied to the claim is found in the variable called CLM\_VBP\_ADJSTMT\_PMT\_AMT.

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## CLM\_VBP\_ADJSTMT\_PMT\_AMT

**LABEL:** Claim Value-Based Purchasing Adjustment Payment Amount

**DESCRIPTION:** This field represents the Hospital Value Based Purchasing (HVBP) Amount.

This could be an additional payment on the claim or a reduction, depending on the hospital's performance score.

**SHORT NAME:** CLM\_VBP\_ADJSTMT\_PMT\_AMT

**LONG NAME:** CLM\_VBP\_ADJSTMT\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX (may be a negative value)

**COMMENT:** This initiative began in 4th Quarter of 2013 (i.e., beginning of Federal fiscal year 14 [FY14]). This field was new in 2013, and is null/missing for all previous years.

The HVBP applies only to subsection (d) Inpatient Prospective Payment System (IPPS) hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (see CLM\_VBP\_PRTCNT\_IND\_CD).

This amount is based on a VBP adjustment percent (variable called CLM\_VBP\_ADJSTMT\_PCT) that is applied to the base operating DRG amount, depending on the hospital's Total Performance Score (TPS), which is the Value Based Purchasing Score.

HVBP is required by the Affordable Care Act (ACA). The percentages change each FY. Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

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## CLM\_VBP\_PRTCPNT\_IND\_CD

|                     |                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Value-Based Purchasing (VBP) Participant Indicator Code                                                                                                                                                                                                                                                                                                          |
| <b>DESCRIPTION:</b> | This field is the code used to identify a reason a hospital is excluded from the Hospital Value Based Purchasing (HVBP) program.                                                                                                                                                                                                                                       |
| <b>SHORT NAME:</b>  | CLM_VBP_PRTCPNT_IND_CD                                                                                                                                                                                                                                                                                                                                                 |
| <b>LONG NAME:</b>   | CLM_VBP_PRTCPNT_IND_CD                                                                                                                                                                                                                                                                                                                                                 |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                                                                                                                   |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                                                                                                                                                                                                      |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                    |
| <b>VALUES:</b>      | Y = Participating in Hospital Value Based Purchasing<br>N = Not participating in Hospital Value Based Purchasing<br>Null/missing = same as 'N'                                                                                                                                                                                                                         |
| <b>COMMENT:</b>     | <p>The ACA (Section 3001) excludes from the HVBP hospitals that meet certain conditions. Additional information is available on the CMS "Hospital Value-Based Purchasing" website.</p> <p>This initiative began in 4th Quarter of 2013 (i.e., beginning of Federal fiscal year 14).</p> <p>This field was new in 2013, and is null/missing for all previous years.</p> |

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## CPO\_ORG\_NPI\_NUM

**LABEL:** CPO Organization NPI Number

**DESCRIPTION:** The National Provider Identifier (NPI) number of the Home Health Agency (HHA) or Hospice rendering Medicare services during the period the physician is providing care plan oversight (CPO).

**SHORT NAME:** CPO\_ORG\_NPI\_NUM

**LONG NAME:** CPO\_ORG\_NPI\_NUM

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or Hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.

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## CPO\_PRVDR\_NUM

|                     |                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Care Plan Oversight (CPO) Provider Number                                                                                                                                                                                                                                                                                                                                                |
| <b>DESCRIPTION:</b> | The National Provider Identifier (NPI) number of the Home Health Agency (HHA) or Hospice rendering Medicare services during the period the physician is providing care plan oversight (CPO).                                                                                                                                                                                             |
| <b>SHORT NAME:</b>  | CPO_PRVDR_NUM                                                                                                                                                                                                                                                                                                                                                                            |
| <b>LONG NAME:</b>   | CPO_PRVDR_NUM                                                                                                                                                                                                                                                                                                                                                                            |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>LENGTH:</b>      | 10                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>VALUES:</b>      | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>COMMENT:</b>     | The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or Hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim. |

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## DEMO\_ID\_NUM

**LABEL:** Demonstration number

**DESCRIPTION:** The number assigned to identify a CMS demonstration project.

This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

**SHORT NAME:** DEMO\_ID\_NUM

**LONG NAME:** DEMO\_ID\_NUM

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.
- 02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.
- 03 = Telemedicine Demo -- testing covering traditionally non-covered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.
- 04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X', '21X', '28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.
- 05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site. NOTE - this demonstration was terminated 12/31/2000.
- 06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'. NOTE - this demonstration was terminated in 1998.
- 07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery

physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'. NOTE - The implementation date for this demonstration is 4/1/03.

- 08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.
  
- 15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.
  
- 30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.
  
- 31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- NCH WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (CMS) (not in Nearline File).
  
- 37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.
  
- 37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare diagnosed, beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).

- 38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. **\*\*NOT IN NCH.\*\*** NOTE - Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.
- 39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing. NOTE - Effective October, 2000 for carrier claims.
- 40 = Payment of Physician and Non-physician Services in certain Indian Providers -- the purpose of this demo is to extend payment for services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule. NOTE - Effective July 1, 2001 for institutional and carrier claims.
- 48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home. NOTE - Effective July 5, 2005 for HHA claims.
- 49 = Hemodialysis
- 53 = Extended Stay
- 54 = ACE Demo
- 58 = used to identify the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration. (eff. 7/2/12)
- 59 = ACO Pioneer Demonstration (eff. 1/2014)
- 61 = CLM-CARE-IMPRVMT-MODEL-1
- 62 = CLM-CARE-IMPRVMT-MODEL-2
- 63 = CLM-CARE-IMPRVMT-MODEL-3
- 64 = CLM-CARE-IMPRVMT-MODEL-4

- 65 = rebilled claims due to auditor denials -- code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12)
- 66 = rebilled claims due to provider self-audit after claim submission/payment -- code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12)
- 67 = rebilled claims due to provider self-audit after the patient has been discharged, but prior to payment -- code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12)
- 68 = NCH will not apply the 3-day hospital stay requirement when processing a SNF claim. (eff. 1/2014)
- 70 = used for Electrical Workers Insurance Fund claims. (eff. 7/2/12)
- 74 = unknown value
- 77 = Shared Savings Program (eff. 10/2016)
- 78 = Comprehensive Primary Care Plus (CPC+) (eff. 4/2017)

**COMMENT:** -

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## DEMO\_ID\_SQNC\_NUM

**LABEL:** Demonstration sequence number

**DESCRIPTION:** The number of demonstration identification trailers present on the claim.

**SHORT NAME:** DEMO\_ID\_SQNC\_NUM

**LONG NAME:** DEMO\_ID\_SQNC\_NUM

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** The demonstration sequence number is a sequential line number to distinguish distinct demonstration projects that affect the same claim.

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## DEMO\_INFO\_TXT

**LABEL:** Demonstration information text

**DESCRIPTION:** This is a text field that contains information related to the demonstration.

For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

**SHORT NAME:** DEMO\_INFO\_TXT

**LONG NAME:** DEMO\_INFO\_TXT

**TYPE:** CHAR

**LENGTH:** 15

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** When the Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'.

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## DMERC\_LINE\_MTUS\_CD

**LABEL:** DMERC Line Miles/Time/ Units/Services (MTUS) Indicator Code

**DESCRIPTION:** Code indicating the units associated with services needing unit reporting on the line item for the DMERC service.

**SHORT NAME:** UNIT\_IND

**LONG NAME:** DMERC\_LINE\_MTUS\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** 0 = Values reported as zero

1 = (rarely used)

2 = (rarely used)

3 = Number of services

4 = Oxygen volume units

6 = Drug dosage (valid 2004 and earlier) - Since early 1994 this value has incorrectly been placed on DMERC claims. The DMERCs were overriding the MTUS indicator with a '6' if the claim was submitted with an NDC code.

NOTE: This problem has been corrected -- no date on when the correction became effective.

**COMMENT:** -

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## DMERC\_LINE\_MTUS\_CNT

**LABEL:** DMERC Line Miles/Time/Units/Services (MTUS) Count

**DESCRIPTION:** The count of the total units associated with services needing unit reporting such as number of supplies, volume of oxygen or nutritional units.

This is a line item field on the DMERC claim and is used for both allowed and denied services.

**SHORT NAME:** DME\_UNIT

**LONG NAME:** DMERC\_LINE\_MTUS\_CNT

**TYPE:** NUM

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Prior to Version 'J', this field was S9(3)

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## DMERC\_LINE\_PRCNG\_STATE\_CD

**LABEL:** DMERC Line Pricing State Code (SSA)

**DESCRIPTION:** The 2-digit SSA state code where the durable medical equipment (DME) supplier was located; used by the Medicare Administrative Contractor (MAC) for pricing the service.

**SHORT NAME:** PRCNG\_ST

**LONG NAME:** DMERC\_LINE\_PRCNG\_STATE\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

|    |   |                      |
|----|---|----------------------|
| 01 | = | Alabama              |
| 02 | = | Alaska               |
| 03 | = | Arizona              |
| 04 | = | Arkansas             |
| 05 | = | California           |
| 06 | = | Colorado             |
| 07 | = | Connecticut          |
| 08 | = | Delaware             |
| 09 | = | District of Columbia |
| 10 | = | Florida              |
| 11 | = | Georgia              |
| 12 | = | Hawaii               |
| 13 | = | Idaho                |
| 14 | = | Illinois             |
| 15 | = | Indiana              |
| 16 | = | Iowa                 |
| 17 | = | Kansas               |
| 18 | = | Kentucky             |
| 19 | = | Louisiana            |
| 20 | = | Maine                |
| 21 | = | Maryland             |
| 22 | = | Massachusetts        |
| 23 | = | Michigan             |
| 24 | = | Minnesota            |
| 25 | = | Mississippi          |
| 26 | = | Missouri             |
| 27 | = | Montana              |
| 28 | = | Nebraska             |
| 29 | = | Nevada               |
| 30 | = | New Hampshire        |
| 31 | = | New Jersey           |

32 = New Mexico  
 33 = New York  
 34 = North Carolina  
 35 = North Dakota  
 36 = Ohio  
 37 = Oklahoma  
 38 = Oregon  
 39 = Pennsylvania  
 40 = Puerto Rico  
 41 = Rhode Island  
 42 = South Carolina  
 43 = South Dakota  
 44 = Tennessee  
 45 = Texas  
 46 = Utah  
 47 = Vermont  
 48 = Virgin Islands  
 49 = Virginia  
 50 = Washington  
 51 = West Virginia  
 52 = Wisconsin  
 53 = Wyoming  
 54 = Africa  
 55 = California  
 56 = Canada & Islands  
 57 = Central America and West Indies  
 58 = Europe  
 59 = Mexico  
 60 = Oceania  
 61 = Philippines  
 62 = South America  
 63 = U.S. Possessions  
 64 = American Samoa  
 65 = Guam  
 66 = Commonwealth of the Northern Marianas Islands  
 67 = Texas  
 68 = Florida (eff. 10/2005)  
 69 = Florida (eff. 10/2005)  
 70 = Kansas (eff. 10/2005)  
 71 = Louisiana (eff. 10/2005)  
 72 = Ohio (eff. 10/2005)  
 73 = Pennsylvania (eff. 10/2005)  
 74 = Texas (eff. 10/2005)  
 80 = Maryland (eff. 8/2000)

- 97 = Northern Marianas
- 98 = Guam
- 99 = With 000 county code is American Samoa; otherwise unknown

**COMMENT:** -

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## DMERC\_LINE\_SCRN\_SVGS\_AMT

**LABEL:** DMERC Line Screen Savings Amount

**DESCRIPTION:** The amount of savings attributable to the coverage screen for this DMERC line item.

**SHORT NAME:** SCRNSVGS

**LONG NAME:** DMERC\_LINE\_SCRN\_SVGS\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## DMERC\_LINE\_SUPPLR\_TYPE\_CD

**LABEL:** DMERC Line Supplier Type Code

**DESCRIPTION:** The type of DMERC supplier.

**SHORT NAME:** SUP\_TYPE

**LONG NAME:** DMERC\_LINE\_SUPPLR\_TYPE\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
- 1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
- 2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
- 3 = Suppliers (other than sole proprietorship) for whom employer identification (EI) numbers are used in coding the ID field.
- 4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
- 5 = Institutional providers and independent laboratories for whom employer identification (EI) numbers are used in coding the ID field.
- 6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
- 7 = Clinics, groups, associations, or partnerships for whom employer identification (EI) numbers are used in coding the ID field.
- 8 = Other entities for whom employer identification (EI) numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

**COMMENT:** -

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## DOB\_DT

**LABEL:** Date of Birth from Claim

**DESCRIPTION:** The beneficiary's date of birth.

**SHORT NAME:** DOB\_DT

**LONG NAME:** DOB\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## DSH\_OP\_CLM\_VAL\_AMT

**LABEL:** Operating Disproportionate Share (DSH) Amount

**DESCRIPTION:** This is one component of the total amount that is payable on prospective payment system (PPS) claims, and reflects the DSH (disproportionate share hospital) payments for operating expenses (such as labor) for the claim.

There are two types of DSH amounts that may be payable for many PPS claims; the other type of DSH payment is for the DSH capital amount (variable called CLM\_PPS\_CPTL\_DSPRPRTNT\_SHR\_AMT).

Both operating and capital DSH payments are components of the PPS, as well as numerous other factors.

**SHORT NAME:** DSH\_OP

**LONG NAME:** DSH\_OP\_CLM\_VAL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

**DERIVATION RULES:** If there is a value code '18' (i.e., in the Value Code File, if the VAL\_CD='18') then this dollar amount (VAL\_AMT) is used to populate this field."

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## **EHR\_PGM\_RDCTN\_IND\_SW**

**LABEL:** Claim Electronic Health Records (EHR) Program Reduction Indicator Switch

**DESCRIPTION:** This field is a switch that identifies which hospitals are Electronic Health Records(EHR) meaningful users, and distinguishes hospitals that will have a payment penalty for not being meaningful users.

**SHORT NAME:** EHR\_PGM\_RDCTN\_IND\_SW

**LONG NAME:** EHR\_PGM\_RDCTN\_IND\_SW

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Y = hospital is subject to a reduction under the EHR program  
Blank = not applicable

**COMMENT:** This field is new in October 2014. This field only applies to Inpatient claims.

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## **EHR\_PYMT\_ADJSTMT\_AMT**

**LABEL:** Claim Electronic Health Record (EHR) Payment Adjustment Amount

**DESCRIPTION:** The claims adjustment payment amount for Hospitals that are not meaningful users of certified Electronic Health Record (EHR) technology.

**SHORT NAME:** EHR\_PYMT\_ADJSTMT\_AMT

**LONG NAME:** EHR\_PYMT\_ADJSTMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field was new in 2012, and is null/missing for all previous years.

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## FI\_CLM\_ACTN\_CD

**LABEL:** FI or MAC Claim Action Code

**DESCRIPTION:** The type of action requested by the intermediary to be taken on an institutional claim.

**SHORT NAME:** ACTIONCD

**LONG NAME:** FI\_CLM\_ACTN\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** 1 = Original debit action (always a 1 for all regular bills)

5 = Force action code 3 (secondary debit adjustment)

8 = Benefits refused

**COMMENT:** -

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## FI\_CLM\_PROC\_DT

**LABEL:** FI Claim Process Date

**DESCRIPTION:** The date the fiscal intermediary completes processing and releases the institutional claim to the CMS common working file (CWF; stored in the NCH).

**SHORT NAME:** FI\_CLM\_PROC\_DT

**LONG NAME:** FI\_CLM\_PROC\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## FI\_NUM

**LABEL:** FI or MAC Number

**DESCRIPTION:** The identification number assigned by CMS to a fiscal intermediary (FI) authorized to process institutional claim records.

Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

**SHORT NAME:** FI\_NUM

**LONG NAME:** FI\_NUM

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** Different FI/MAC carriers are under contract with CMS at different times.

See the CMS website for MAC Contract Status (for example):

<http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACContractStatus.html>

Fiscal Intermediary Numbers (as of June 2004):

| State                              | Contract | Contractor      | Identifier |
|------------------------------------|----------|-----------------|------------|
| Multiple                           | FI       | Mutual of Omaha | 52280      |
| Alabama                            | FI       | Cahaba          | 00010      |
| Alaska                             | FI       | Noridian        | 00322      |
| Arizona                            | FI       | BCBS Arizona    | 00030      |
| Arkansas                           | FI       | BCBS Arkansas   | 00020      |
| California                         | FI       | UGS             | 00454      |
| Colorado                           | FI       | TrailBlazer     | 00400      |
| Connecticut                        | FI       | Empire          | 00308      |
| Delaware                           | FI       | Empire          | 00308      |
| D.C.                               | FI       | Carefirst of MD | 00190      |
| Florida                            | FI       | First Coast     | 00090      |
| Georgia                            | FI       | BCBS Georgia    | 00101      |
| Hawaii*                            | FI       | UGS             | 00454      |
| * Includes Guam and American Samoa |          |                 |            |
| Idaho                              | FI       | Regence         | 00350      |
| Illinois                           | FI       | AdminaStar      | 00131      |
| Indiana                            | FI       | AdminaStar      | 00130      |
| Iowa                               | FI       | Cahaba          | 00011      |
| Kansas                             | FI       | BCBS Kansas     | 00150      |

|                          |    |                           |       |
|--------------------------|----|---------------------------|-------|
| Kentucky                 | FI | AdminaStar                | 00160 |
| Louisiana                | FI | Trispan                   | 00230 |
| Maine                    | FI | Associated Hospital of ME | 00180 |
| Maryland                 | FI | Carefirst of Maryland     | 00190 |
| Massachusetts            | FI | Associated Hospital of ME | 00181 |
| Michigan                 | FI | UGS                       | 00452 |
| Minnesota                | FI | Noridian                  | 00320 |
| Mississippi              | FI | Trispan                   | 00230 |
| Missouri                 | FI | Trispan                   | 00230 |
| Montana                  | FI | BCBS Montana              | 00250 |
| Nebraska                 | FI | BCBS Nebraska             | 00260 |
| Nevada                   | FI | UGS                       | 00454 |
| New Hampshire            | FI | BCBS NH/VT                | 00270 |
| New Jersey               | FI | Riverbend                 | 00390 |
| New Mexico               | FI | TrailBlazer               | 00400 |
| New York                 | FI | Empire                    | 00308 |
| North Carolina           | FI | Palmetto                  | 00382 |
| North Dakota             | FI | Noridian                  | 00320 |
| Ohio                     | FI | AdminaStar                | 00332 |
| Oklahoma                 | FI | BCBS Oklahoma             | 00340 |
| Oregon                   | FI | Regence                   | 00350 |
| Pennsylvania             | FI | Veritus                   | 00363 |
| Puerto Rico*             | FI | Cooperativa               | 57400 |
| *Includes Virgin Islands |    |                           |       |
| Rhode Island             | FI | Arkansas BCBS             | 00021 |
| South Carolina           | FI | Palmetto                  | 00380 |
| South Dakota             | FI | Cahaba                    | 00011 |
| Tennessee                | FI | Riverbend                 | 00390 |
| Texas                    | FI | TrailBlazer               | 00400 |
| Utah                     | FI | Regence                   | 00350 |
| Vermont                  | FI | BCBS NH/VT                | 00270 |
| Virginia                 | FI | UGS                       | 00453 |
| Washington               | FI | Noridian                  | 00322 |
| West Virginia            | FI | UGS                       | 00453 |
| Wisconsin                | FI | UGS                       | 00450 |
| Wyoming                  | FI | BCBS Wyoming              | 00460 |

**COMMENT:** -

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## FINL\_STD\_AMT

**LABEL:** Claim Final Standard Payment Amount

**DESCRIPTION:** This amount further adjusts the standard Medicare Payment amount (field called PPS\_STD\_VAL\_PYMT\_AMT) by applying additional standardization requirements (e.g. sequestration).

**SHORT NAME:** FINL\_STD\_AMT

**LONG NAME:** FINL\_STD\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XX.XX

**COMMENT:** This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard Medicare payment amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the hospitals.

This field is new in October 2014. This field only applies to Inpatient claims.

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## FROM\_DT

**LABEL:** Claim From Date

**DESCRIPTION:** The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

**SHORT NAME:** FROM\_DT

**LONG NAME:** CLM\_FROM\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For Home Health prospective payment system (PPS) claims, the 'from' date and the 'thru' date on the RAP (Request for Anticipated Payment) initial claim must always match.

The "from" date on the claim may not always represent the first date of services, particularly for Home Health or Hospice care. To obtain the date corresponding with the onset of services (or admission date) use the admission date from the claim (variable called CLM\_ADMSN\_DT for IP, SNF and HH - and variable called CLM\_HOSPC\_START\_DT\_ID for Hospice claims).

For Part B Non-institutional (Carrier and DME) services, this variable corresponds with the earliest of any of the line-item level dates (i.e., in the Line File, it is the first CLM\_FROM\_DT for any line on the claim). It is almost always the same as the CLM\_THRU\_DT; exception is for DME claims - where some services are billed in advance.

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## FST\_DGNS\_E\_CD

**LABEL:** First Claim Diagnosis E Code

**DESCRIPTION:** The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.

**SHORT NAME:** FST\_DGNS\_E\_CD

**LONG NAME:** FST\_DGNS\_E\_CD

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Prior to version 'J', this field was named: CLM\_DGNS\_E\_CD.

Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## FST\_DGNS\_E\_VRSN\_CD

**LABEL:** First Claim Diagnosis E Code Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis E code is ICD-9 or ICD-10.

**SHORT NAME:** FST\_DGNS\_E\_VRSN\_CD

**LONG NAME:** FST\_DGNS\_E\_VRSN\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** -

**VALUES:** Blank = ICD-9  
9 = ICD-9  
0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes were expanded to accommodate the future implementation of ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## **GNDR\_CD**

**LABEL:** Gender Code from Claim

**DESCRIPTION:** The sex of a beneficiary.

**SHORT NAME:** GNDR\_CD

**LONG NAME:** GNDR\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** SSA, RRB, EDB

**VALUES:** 0 = Unknown

1 = Male

2 = Female

**COMMENT:** -

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## HAC\_PGM\_RDCTN\_IND\_SW

**LABEL:** Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Switch

**DESCRIPTION:** This field is a switch that identifies hospitals subject to a Hospital Acquired Conditions (HAC) reduction of what they would otherwise be paid under the inpatient prospective payment system (IPPS).

**SHORT NAME:** HAC\_PGM\_RDCTN\_IND\_SW

**LONG NAME:** HAC\_PGM\_RDCTN\_IND\_SW

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Y = hospital subject to a reduction under the HAC Reduction Program  
N = hospital is not subject to a reduction under the HAC Reduction Program

**COMMENT:** This field is new in October 2014. This field only applies to Inpatient claims.

For details on the CMS hospital readmission reduction program see the CMS website:  
<http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>

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## HCPCS\_1ST\_MDFR\_CD

**LABEL:** HCPCS Initial Modifier Code

**DESCRIPTION:** A first modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to enable a more specific procedure identification for the revenue center or line item service for the claim.

**SHORT NAME:** MDFR\_CD1

**LONG NAME:** HCPCS\_1ST\_MDFR\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## HCPCS\_2ND\_MDFR\_CD

**LABEL:** HCPCS Second Modifier Code

**DESCRIPTION:** A second modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first modifier code to identify the revenue center or line item service for the claim.

**SHORT NAME:** MDFR\_CD2

**LONG NAME:** HCPCS\_2ND\_MDFR\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## HCPCS\_3RD\_MDFR\_CD

**LABEL:** HCPCS Third Modifier Code

**DESCRIPTION:** A third modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first or second modifier codes to identify the revenue center or line item services for the claim.

**SHORT NAME:** MDFR\_CD3

**LONG NAME:** HCPCS\_3RD\_MDFR\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## HCPCS\_4TH\_MDFR\_CD

**LABEL:** HCPCS Fourth Modifier Code

**DESCRIPTION:** A fourth modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first, second, or third modifier codes identify the revenue center or line item services for the claim.

**SHORT NAME:** MDFR\_CD4

**LONG NAME:** HCPCS\_4TH\_MDFR\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** This field is available only in the Hospital Outpatient data file (not other claim types).

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## HCPCS\_CD

**LABEL:** Healthcare Common Procedure Coding System (HCPCS) Code

**DESCRIPTION:** The Healthcare 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 (in COMMENT):

In the Institutional Claim Revenue Center Files, this variable can indicate the specific case-mix grouping that Medicare used to pay for skilled nursing facility (SNF), home health, or inpatient rehabilitation facility (IRF) services (see Note 2 in COMMENT section below).

**SHORT NAME:** HCPCS\_CD

**LONG NAME:** HCPCS\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** 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 non-physician services.

\*\*\*\* Note 1: \*\*\*\*

CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/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, Fifth Edition (CDT-5). 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 CMS, 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 non-physician services that are not represented in the level I codes.

Level III

Codes and descriptors developed by Medicare carriers (currently known as Medicare Administrative Contractors; MACs) for use at the local (MAC) level. These are 5-position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in the level I or level II codes.

\*\*\*\* Note 2: \*\*\*\*

This field may contain information regarding case-mix grouping that Medicare used to pay for SNF, home health, or IRF services. These groupings are sometimes known as Health Insurance Prospective Payment System (HIPPS) codes.

This field will contain a HIPPS code if the revenue center code (REV\_CNTR) equals 0022 for SNF care, 0023 for home health, or 0024 for IRF care.

For home health claims, please also see the revenue center APC/HIPPS code variable (REV\_CNTR\_APC\_HIPPS\_CD).

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## HPSA\_SCRCTY\_IND\_CD

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Carrier Line Health Professional Shortage Area (HPSA)/Scarcity Indicator Code                                                                                                                                                                                                                                                                                                                                               |
| <b>DESCRIPTION:</b> | The code used to track health professional shortage area (HPSA) and physician scarcity bonus payments on carrier claims.                                                                                                                                                                                                                                                                                                    |
| <b>SHORT NAME:</b>  | HPSASCCD                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>LONG NAME:</b>   | HPSA_SCRCTY_IND_CD                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>VALUES:</b>      | 1 = HPSA<br>2 = Scarcity<br>3 = Both<br>Space = Not applicable                                                                                                                                                                                                                                                                                                                                                              |
| <b>COMMENT:</b>     | <p>This variable was added 10/3/2005 with the implementation of NCH/NMUD CR#2.</p> <p>Prior to 10/3/2005, claims contained a modifier code to indicate the bonus payment. A 'QU' represented a HPSA bonus payment and an 'AR' represented a scarcity bonus payment. As of 1/1/2005, the modifiers were no longer being reported by the provider. NCH &amp; NMUD were not ready to accept the new field until 10/3/2005.</p> |

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## ICD\_DGNS\_CD1

**LABEL:** Claim Diagnosis Code I

**DESCRIPTION:** The diagnosis code identifying the beneficiary's principal diagnosis.

**SHORT NAME:** ICD\_DGNS\_CD1

**LONG NAME:** ICD\_DGNS\_CD1

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD2

**LABEL:** Claim Diagnosis Code II

**DESCRIPTION:** The diagnosis code in the 2<sup>nd</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD2

**LONG NAME:** ICD\_DGNS\_CD2

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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### ICD\_DGNS\_CD3

**LABEL:** Claim Diagnosis Code III

**DESCRIPTION:** The diagnosis code in the 3<sup>rd</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD3

**LONG NAME:** ICD\_DGNS\_CD3

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD4

**LABEL:** Claim Diagnosis Code IV

**DESCRIPTION:** The diagnosis code in the 4<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD4

**LONG NAME:** ICD\_DGNS\_CD4

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD5

**LABEL:** Claim Diagnosis Code V

**DESCRIPTION:** The diagnosis code in the 5<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD5

**LONG NAME:** ICD\_DGNS\_CD5

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD6

**LABEL:** Claim Diagnosis Code VI

**DESCRIPTION:** The diagnosis code in the 6<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD6

**LONG NAME:** ICD\_DGNS\_CD6

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD7

**LABEL:** Claim Diagnosis Code VII

**DESCRIPTION:** The diagnosis code in the 7<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD7

**LONG NAME:** ICD\_DGNS\_CD7

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD8

**LABEL:** Claim Diagnosis Code VIII

**DESCRIPTION:** The diagnosis code in the 8<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD8

**LONG NAME:** ICD\_DGNS\_CD8

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD9

**LABEL:** Claim Diagnosis Code IX

**DESCRIPTION:** The diagnosis code in the 9<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD9

**LONG NAME:** ICD\_DGNS\_CD9

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD10

**LABEL:** Claim Diagnosis Code X

**DESCRIPTION:** The diagnosis code in the 10<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD10

**LONG NAME:** ICD\_DGNS\_CD10

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD11

**LABEL:** Claim Diagnosis Code XI

**DESCRIPTION:** The diagnosis code in the 11<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD11

**LONG NAME:** ICD\_DGNS\_CD11

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD12

**LABEL:** Claim Diagnosis Code XII

**DESCRIPTION:** The diagnosis code in the 12<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD12

**LONG NAME:** ICD\_DGNS\_CD12

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD13

**LABEL:** Claim Diagnosis Code XIII

**DESCRIPTION:** The diagnosis code in the 13<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD13

**LONG NAME:** ICD\_DGNS\_CD13

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD14

**LABEL:** Claim Diagnosis Code XIV

**DESCRIPTION:** The diagnosis code in the 14<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD14

**LONG NAME:** ICD\_DGNS\_CD14

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD15

**LABEL:** Claim Diagnosis Code XV

**DESCRIPTION:** The diagnosis code in the 15<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD15

**LONG NAME:** ICD\_DGNS\_CD15

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD16

**LABEL:** Claim Diagnosis Code XVI

**DESCRIPTION:** The diagnosis code in the 16<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD16

**LONG NAME:** ICD\_DGNS\_CD16

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD17

**LABEL:** Claim Diagnosis Code XVII

**DESCRIPTION:** The diagnosis code in the 17<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD17

**LONG NAME:** ICD\_DGNS\_CD17

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD18

**LABEL:** Claim Diagnosis Code XVIII

**DESCRIPTION:** The diagnosis code in the 18<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD18

**LONG NAME:** ICD\_DGNS\_CD18

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD19

**LABEL:** Claim Diagnosis Code XIX

**DESCRIPTION:** The diagnosis code in the 19<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD19

**LONG NAME:** ICD\_DGNS\_CD19

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD20

**LABEL:** Claim Diagnosis Code XX

**DESCRIPTION:** The diagnosis code in the 20<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD20

**LONG NAME:** ICD\_DGNS\_CD20

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD21

**LABEL:** Claim Diagnosis Code XXI

**DESCRIPTION:** The diagnosis code in the 21<sup>st</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD21

**LONG NAME:** ICD\_DGNS\_CD21

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD22

**LABEL:** Claim Diagnosis Code XXII

**DESCRIPTION:** The diagnosis code in the 22<sup>nd</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD22

**LONG NAME:** ICD\_DGNS\_CD22

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD23

**LABEL:** Claim Diagnosis Code XXIII

**DESCRIPTION:** The diagnosis code in the 23<sup>rd</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD23

**LONG NAME:** ICD\_DGNS\_CD23

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD24

**LABEL:** Claim Diagnosis Code XXIV

**DESCRIPTION:** The diagnosis code in the 24<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD24

**LONG NAME:** ICD\_DGNS\_CD24

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_CD25

**LABEL:** Claim Diagnosis Code XXV

**DESCRIPTION:** The diagnosis code in the 25<sup>th</sup> position identifying the condition(s) for which the beneficiary is receiving care.

**SHORT NAME:** ICD\_DGNS\_CD25

**LONG NAME:** ICD\_DGNS\_CD25

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD\_DGNS\_CD1 is considered the primary diagnosis).

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## ICD\_DGNS\_E\_CD1

**LABEL:** Claim Diagnosis E Code I

**DESCRIPTION:** The code used to identify the 1st external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD1

**LONG NAME:** ICD\_DGNS\_E\_CD1

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD2

**LABEL:** Claim Diagnosis E Code II

**DESCRIPTION:** The code used to identify the 2<sup>nd</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD2

**LONG NAME:** ICD\_DGNS\_E\_CD2

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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### ICD\_DGNS\_E\_CD3

**LABEL:** Claim Diagnosis E Code III

**DESCRIPTION:** The code used to identify the 3<sup>rd</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD3

**LONG NAME:** ICD\_DGNS\_E\_CD3

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD4

**LABEL:** Claim Diagnosis E Code IV

**DESCRIPTION:** The code used to identify the 4th external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD4

**LONG NAME:** ICD\_DGNS\_E\_CD4

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD5

**LABEL:** Claim Diagnosis E Code V

**DESCRIPTION:** The code used to identify the 5<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD5

**LONG NAME:** ICD\_DGNS\_E\_CD5

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD6

**LABEL:** Claim Diagnosis E Code VI

**DESCRIPTION:** The code used to identify the 6<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD6

**LONG NAME:** ICD\_DGNS\_E\_CD6

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD7

**LABEL:** Claim Diagnosis E Code VII

**DESCRIPTION:** The code used to identify the 7<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD7

**LONG NAME:** ICD\_DGNS\_E\_CD7

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD8

**LABEL:** Claim Diagnosis E Code VIII

**DESCRIPTION:** The code used to identify the 8<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD8

**LONG NAME:** ICD\_DGNS\_E\_CD8

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD9

**LABEL:** Claim Diagnosis E Code IX

**DESCRIPTION:** The code used to identify the 9<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD9

**LONG NAME:** ICD\_DGNS\_E\_CD9

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD10

**LABEL:** Claim Diagnosis E Code X

**DESCRIPTION:** The code used to identify the 10<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD10

**LONG NAME:** ICD\_DGNS\_E\_CD10

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD11

**LABEL:** Claim Diagnosis E Code XI

**DESCRIPTION:** The code used to identify the 11<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD11

**LONG NAME:** ICD\_DGNS\_E\_CD11

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_CD12

**LABEL:** Claim Diagnosis E Code XII

**DESCRIPTION:** The code used to identify the 12<sup>th</sup> external cause of injury, poisoning, or other adverse effect.

**SHORT NAME:** ICD\_DGNS\_E\_CD12

**LONG NAME:** ICD\_DGNS\_E\_CD12

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD1

**LABEL:** Claim Diagnosis E Code I Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD1

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD2

**LABEL:** Claim Diagnosis E Code II Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD2

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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### ICD\_DGNS\_E\_VRSN\_CD3

**LABEL:** Claim Diagnosis E Code III Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD3

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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#### ICD\_DGNS\_E\_VRSN\_CD4

**LABEL:** Claim Diagnosis E Code IV Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD4

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD4

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD5

**LABEL:** Claim Diagnosis E Code V Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD5

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD6

**LABEL:** Claim Diagnosis E Code VI Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD6

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD6

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD7

**LABEL:** Claim Diagnosis E Code VII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD7

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD7

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD8

**LABEL:** Claim Diagnosis E Code VIII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD8

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD8

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD9

**LABEL:** Claim Diagnosis E Code IX Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD9

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD9

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD10

**LABEL:** Claim Diagnosis E Code X Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD10

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD10

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD11

**LABEL:** Claim Diagnosis E Code XI Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD11

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD11

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_E\_VRSN\_CD12

**LABEL:** Claim Diagnosis E Code XII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_E\_VRSN\_CD12

**LONG NAME:** ICD\_DGNS\_E\_VRSN\_CD12

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD1

|                     |                                                                                                                                                       |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Diagnosis Code I Diagnosis Version Code (ICD-9 or ICD-10)                                                                                       |
| <b>DESCRIPTION:</b> | Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.                                                          |
| <b>SHORT NAME:</b>  | ICD_DGNS_VRSN_CD1                                                                                                                                     |
| <b>LONG NAME:</b>   | ICD_DGNS_VRSN_CD1                                                                                                                                     |
| <b>TYPE:</b>        | CHAR                                                                                                                                                  |
| <b>LENGTH:</b>      | 1                                                                                                                                                     |
| <b>SOURCE:</b>      | NCH                                                                                                                                                   |
| <b>VALUES:</b>      | Blank = ICD-9<br>9 = ICD-9<br>0 = ICD-10                                                                                                              |
| <b>COMMENT:</b>     | On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. |

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## ICD\_DGNS\_VRSN\_CD2

**LABEL:** Claim Diagnosis Code II Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD2

**LONG NAME:** ICD\_DGNS\_VRSN\_CD2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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### ICD\_DGNS\_VRSN\_CD3

**LABEL:** Claim Diagnosis Code III Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD3

**LONG NAME:** ICD\_DGNS\_VRSN\_CD3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD4

**LABEL:** Claim Diagnosis Code IV Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD4

**LONG NAME:** ICD\_DGNS\_VRSN\_CD4

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD5

**LABEL:** Claim Diagnosis Code V Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD5

**LONG NAME:** ICD\_DGNS\_VRSN\_CD5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD6

**LABEL:** Claim Diagnosis Code VI Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD6

**LONG NAME:** ICD\_DGNS\_VRSN\_CD6

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD7

**LABEL:** Claim Diagnosis Code VII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD7

**LONG NAME:** ICD\_DGNS\_VRSN\_CD7

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD8

**LABEL:** Claim Diagnosis Code VIII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD8

**LONG NAME:** ICD\_DGNS\_VRSN\_CD8

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD9

**LABEL:** Claim Diagnosis Code IX Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD9

**LONG NAME:** ICD\_DGNS\_VRSN\_CD9

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD10

**LABEL:** Claim Diagnosis Code X Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD10

**LONG NAME:** ICD\_DGNS\_VRSN\_CD10

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD11

**LABEL:** Claim Diagnosis Code XI Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD11

**LONG NAME:** ICD\_DGNS\_VRSN\_CD11

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD12

**LABEL:** Claim Diagnosis Code XII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD12

**LONG NAME:** ICD\_DGNS\_VRSN\_CD12

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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### ICD\_DGNS\_VRSN\_CD13

**LABEL:** Claim Diagnosis Code XIII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD13

**LONG NAME:** ICD\_DGNS\_VRSN\_CD13

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD14

**LABEL:** Claim Diagnosis Code XIV Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD14

**LONG NAME:** ICD\_DGNS\_VRSN\_CD14

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD15

**LABEL:** Claim Diagnosis Code XV Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD15

**LONG NAME:** ICD\_DGNS\_VRSN\_CD15

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD16

**LABEL:** Claim Diagnosis Code XVI Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD16

**LONG NAME:** ICD\_DGNS\_VRSN\_CD16

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD17

**LABEL:** Claim Diagnosis Code XVII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD17

**LONG NAME:** ICD\_DGNS\_VRSN\_CD17

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD18

**LABEL:** Claim Diagnosis Code XVIII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD18

**LONG NAME:** ICD\_DGNS\_VRSN\_CD18

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD19

|                     |                                                                                                                                                       |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim Diagnosis Code XIX Diagnosis Version Code (ICD-9 or ICD-10)                                                                                     |
| <b>DESCRIPTION:</b> | Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.                                                          |
| <b>SHORT NAME:</b>  | ICD_DGNS_VRSN_CD19                                                                                                                                    |
| <b>LONG NAME:</b>   | ICD_DGNS_VRSN_CD19                                                                                                                                    |
| <b>TYPE:</b>        | CHAR                                                                                                                                                  |
| <b>LENGTH:</b>      | 1                                                                                                                                                     |
| <b>SOURCE:</b>      | NCH                                                                                                                                                   |
| <b>VALUES:</b>      | Blank = ICD-9<br>9 = ICD-9<br>0 = ICD-10                                                                                                              |
| <b>COMMENT:</b>     | On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. |

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## ICD\_DGNS\_VRSN\_CD20

**LABEL:** Claim Diagnosis Code XX Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD20

**LONG NAME:** ICD\_DGNS\_VRSN\_CD20

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD21

**LABEL:** Claim Diagnosis Code XXI Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD21

**LONG NAME:** ICD\_DGNS\_VRSN\_CD21

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD22

**LABEL:** Claim Diagnosis Code XXII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD22

**LONG NAME:** ICD\_DGNS\_VRSN\_CD22

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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### ICD\_DGNS\_VRSN\_CD23

**LABEL:** Claim Diagnosis Code XXIII Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD23

**LONG NAME:** ICD\_DGNS\_VRSN\_CD23

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD24

**LABEL:** Claim Diagnosis Code XXIV Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD24

**LONG NAME:** ICD\_DGNS\_VRSN\_CD24

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_DGNS\_VRSN\_CD25

**LABEL:** Claim Diagnosis Code XXV Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** ICD\_DGNS\_VRSN\_CD25

**LONG NAME:** ICD\_DGNS\_VRSN\_CD25

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## ICD\_PRCDR\_CD1

**LABEL:** Claim Procedure Code I

**DESCRIPTION:** The code that indicates the principal or other procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD1

**LONG NAME:** ICD\_PRCDR\_CD1

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD2

**LABEL:** Claim Procedure Code II

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD2

**LONG NAME:** ICD\_PRCDR\_CD2

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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### ICD\_PRCDR\_CD3

**LABEL:** Claim Procedure Code III

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD3

**LONG NAME:** ICD\_PRCDR\_CD3

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD4

**LABEL:** Claim Procedure Code IV

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD4

**LONG NAME:** ICD\_PRCDR\_CD4

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD5

**LABEL:** Claim Procedure Code V

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD5

**LONG NAME:** ICD\_PRCDR\_CD5

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD6

**LABEL:** Claim Procedure Code VI

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD6

**LONG NAME:** ICD\_PRCDR\_CD6

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD7

**LABEL:** Claim Procedure Code VII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD7

**LONG NAME:** ICD\_PRCDR\_CD7

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD8

**LABEL:** Claim Procedure Code VIII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD8

**LONG NAME:** ICD\_PRCDR\_CD8

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD9

**LABEL:** Claim Procedure Code IX

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD9

**LONG NAME:** ICD\_PRCDR\_CD9

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD10

**LABEL:** Claim Procedure Code X

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD10

**LONG NAME:** ICD\_PRCDR\_CD10

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD11

**LABEL:** Claim Procedure Code XI

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD11

**LONG NAME:** ICD\_PRCDR\_CD11

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD12

**LABEL:** Claim Procedure Code XII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD12

**LONG NAME:** ICD\_PRCDR\_CD12

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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### ICD\_PRCDR\_CD13

**LABEL:** Claim Procedure Code XIII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD13

**LONG NAME:** ICD\_PRCDR\_CD13

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD14

**LABEL:** Claim Procedure Code XIV

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD14

**LONG NAME:** ICD\_PRCDR\_CD14

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD15

**LABEL:** Claim Procedure Code XV

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD15

**LONG NAME:** ICD\_PRCDR\_CD15

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD16

**LABEL:** Claim Procedure Code XVI

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD16

**LONG NAME:** ICD\_PRCDR\_CD16

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD17

**LABEL:** Claim Procedure Code XVII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD17

**LONG NAME:** ICD\_PRCDR\_CD17

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD18

**LABEL:** Claim Procedure Code XVIII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD18

**LONG NAME:** ICD\_PRCDR\_CD18

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD19

**LABEL:** Claim Procedure Code XIX

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD19

**LONG NAME:** ICD\_PRCDR\_CD19

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD20

**LABEL:** Claim Procedure Code XX

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD20

**LONG NAME:** ICD\_PRCDR\_CD20

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD21

**LABEL:** Claim Procedure Code XXI

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD21

**LONG NAME:** ICD\_PRCDR\_CD21

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD22

**LABEL:** Claim Procedure Code XXII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD22

**LONG NAME:** ICD\_PRCDR\_CD22

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD23

**LABEL:** Claim Procedure Code XXIII

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD23

**LONG NAME:** ICD\_PRCDR\_CD23

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD24

**LABEL:** Claim Procedure Code XXIV

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD24

**LONG NAME:** ICD\_PRCDR\_CD24

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_CD25

**LABEL:** Claim Procedure Code XXV

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:** ICD\_PRCDR\_CD25

**LONG NAME:** ICD\_PRCDR\_CD25

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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## ICD\_PRCDR\_VRSN\_CD1

**LABEL:** Claim Procedure Code I Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD1

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD2

**LABEL:** Claim Procedure Code II Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD2

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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### ICD\_PRCDR\_VRSN\_CD3

**LABEL:** Claim Procedure Code III Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD3

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD4

**LABEL:** Claim Procedure Code IV Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD4

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD4

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD5

**LABEL:** Claim Procedure Code V Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD5

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD6

**LABEL:** Claim Procedure Code VI Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD6

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD6

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD7

**LABEL:** Claim Procedure Code VII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD7

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD7

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD8

**LABEL:** Claim Procedure Code VIII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD8

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD8

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD9

**LABEL:** Claim Procedure Code IX Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD9

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD9

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD10

**LABEL:** Claim Procedure Code X Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD10

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD10

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD11

**LABEL:** Claim Procedure Code XI Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD11

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD11

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD12

**LABEL:** Claim Procedure Code XII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD12

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD12

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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### ICD\_PRCDR\_VRSN\_CD13

**LABEL:** Claim Procedure Code XIII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD13

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD13

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD14

**LABEL:** Claim Procedure Code XIV Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD14

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD14

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD15

**LABEL:** Claim Procedure Code XV Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD15

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD15

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD16

**LABEL:** Claim Procedure Code XVI Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD16

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD16

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD17

**LABEL:** Claim Procedure Code XVII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD17

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD17

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD18

**LABEL:** Claim Procedure Code XVIII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD18

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD18

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD19

**LABEL:** Claim Procedure Code XIX Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD19

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD19

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD20

**LABEL:** Claim Procedure Code XX Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD20

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD20

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD21

**LABEL:** Claim Procedure Code XXI Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD21

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD21

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD22

**LABEL:** Claim Procedure Code XXII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD22

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD22

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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### ICD\_PRCDR\_VRSN\_CD23

**LABEL:** Claim Procedure Code XXIII Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD23

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD23

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD24

**LABEL:** Claim Procedure Code XXIV Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD24

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD24

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## ICD\_PRCDR\_VRSN\_CD25

**LABEL:** Claim Procedure Code XXV Claim Procedure Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:** ICD\_PRCDR\_VRSN\_CD25

**LONG NAME:** ICD\_PRCDR\_VRSN\_CD25

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9

9 = ICD-9

0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-PCS) occurred.

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## IME\_OP\_CLM\_VAL\_AMT

**LABEL:** Operating Indirect Medical Education (IME) Amount

**DESCRIPTION:** This is one component of the total amount that is payable on PPS claims, and reflects the IME (indirect medical education) payments for operating expenses (such as labor) for the claim.

There are two types of IME amounts that may be payable for many PPS claims; the other type of IME payment is for the IME capital amount (variable called CLM\_PPS\_CPTL\_IME\_AMT). Both operating and capital IME payments are components of the PPS, as well as numerous other factors.

**SHORT NAME:** IME\_OP

**LONG NAME:** IME\_OP\_CLM\_VAL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

Derivation Rules: If there is a value code '19' (i.e., in the Value Code File, if the VAL\_CD='19') then this dollar amount (VAL\_AMT) is used to populate this field.

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## LINE\_1ST\_EXPNS\_DT

**LABEL:** Line First Expense Date

**DESCRIPTION:** Beginning date (1st expense) for this line item service on the non-institutional claim.

**SHORT NAME:** EXPNSDT1

**LONG NAME:** LINE\_1ST\_EXPNS\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## LINE\_ALOWD\_CHRG\_AMT

**LABEL:** Line Allowed Charge Amount

**DESCRIPTION:** The amount of allowed charges for the line item service on the non-institutional claim.

This charge is used to compute the total claim-level payment to providers or reimbursement to beneficiaries.

**SHORT NAME:** LALOWCHG

**LONG NAME:** LINE\_ALOWD\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** The amount includes both the line-item Medicare and beneficiary-paid amounts (i.e., deductible and coinsurance).

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## LINE\_BENE\_PMT\_AMT

**LABEL:** Line Payment Amount to Beneficiary

**DESCRIPTION:** The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.

**SHORT NAME:** LBENPMT

**LONG NAME:** LINE\_BENE\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## LINE\_BENE\_PRMRY\_PYR\_CD

**LABEL:** Line Primary Payer Code (if not Medicare)

**DESCRIPTION:** The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the non-institutional claim.

The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.

**SHORT NAME:** LPRPAYCD

**LONG NAME:** LINE\_BENE\_PRMRY\_PYR\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH,VA,DOL,SSA

**VALUES:**

- A = Working aged bene/spouse with employer group health plan (EGHP)
- B = End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an employer group health plan
- C = Conditional payment by Medicare; future reimbursement expected
- D = Automobile no-fault
- E = Workers' compensation
- F = Public Health Service or other federal agency (other than Dept. of Veterans Affairs)
- G = Working disabled bene (under age 65 with LGHP)
- H = Black Lung
- I = Dept. of Veterans Affairs
- L = Any liability insurance
- M = Override code: EGHP services involved
- N = Override code: non-EGHP services involved
- W = Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)
- Null/missing= Medicare is primary payer

**COMMENT:** Values C, M, N and Null/missing indicate Medicare is primary payer.

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## LINE\_BENE\_PRMRY\_PYR\_PD\_AMT

**LABEL:** Line Primary Payer (if not Medicare) Paid Amount

**DESCRIPTION:** The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for to the line item service on the non-institutional claim.

**SHORT NAME:** LPRPDAMT

**LONG NAME:** LINE\_BENE\_PRMRY\_PYR\_PD\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## LINE\_BENE\_PTB\_DDCTBL\_AMT

**LABEL:** Line Beneficiary Part B Deductible Amount

**DESCRIPTION:** The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line item service on the non-institutional claim.

**SHORT NAME:** LDEDAMT

**LONG NAME:** LINE\_BENE\_PTB\_DDCTBL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## LINE\_CMS\_TYPE\_SRVC\_CD

**LABEL:** Line CMS Type Service Code

**DESCRIPTION:** Code indicating the type of service, as defined in the CMS Medicare Carrier Manual, for this line item on the non-institutional claim.

**SHORT NAME:** TYPSTRVCB

**LONG NAME:** LINE\_CMS\_TYPE\_SRVC\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                   |
|-----|-------------------------------------------------------------------|
| 1 = | Medical care                                                      |
| 2 = | Surgery                                                           |
| 3 = | Consultation                                                      |
| 4 = | Diagnostic radiology                                              |
| 5 = | Diagnostic laboratory                                             |
| 6 = | Therapeutic radiology                                             |
| 7 = | Anesthesia                                                        |
| 8 = | Assistant at surgery                                              |
| 9 = | Other medical items or services                                   |
| 0 = | Whole blood                                                       |
| A = | Used durable medical equipment (DME)                              |
| D = | Ambulance                                                         |
| E = | Enteral/parenteral nutrients/supplies                             |
| F = | Ambulatory surgical center (facility usage for surgical services) |
| G = | Immunosuppressive drugs                                           |
| J = | Diabetic shoes                                                    |
| K = | Hearing items and services                                        |
| L = | ESRD supplies                                                     |
| M = | Monthly capitation payment for dialysis                           |
| N = | Kidney donor                                                      |
| P = | Lump sum purchase of DME, prosthetics orthotics                   |
| Q = | Vision items or services                                          |
| R = | Rental of DME                                                     |
| S = | Surgical dressings or other medical supplies                      |
| T = | Outpatient mental health limitation                               |
| U = | Occupational therapy                                              |
| V = | Pneumococcal/flu vaccine                                          |
| W = | Physical therapy                                                  |

**COMMENT:** -

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## LINE\_COINSRNC\_AMT

**LABEL:** Line Beneficiary Coinsurance Amount

**DESCRIPTION:** The beneficiary coinsurance liability amount for this line item service on the non-institutional claim.

This variable is the beneficiary's liability for coinsurance for the service on the line item record.

Beneficiaries only face coinsurance once they have satisfied Part B's annual deductible, which applies to both institutional (e.g., Hospital Outpatient) and non-institutional (e.g., Carrier and DME) services.

For most Part B services, coinsurance equals 20 percent of the allowed amount.

**SHORT NAME:** COINAMT

**LONG NAME:** LINE\_COINSRNC\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see the list of MLN publications at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## LINE\_DME\_PRCHS\_PRICE\_AMT

**LABEL:** Line DME Purchase Price Amount

**DESCRIPTION:** The amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the cap is met.

This line item field is applicable to non-institutional claims involving DME, prosthetic, orthotic and supply items, immunosuppressive drugs, parenteral nutrition (PEN), ESRD and oxygen items referred to as DMEPOS.

**SHORT NAME:** DME\_PURC

**LONG NAME:** LINE\_DME\_PRCHS\_PRICE\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## LINE\_HCT\_HGB\_RSLT\_NUM

**LABEL:** Hematocrit / Hemoglobin Test Results

**DESCRIPTION:** This is the laboratory value for the most recent hematocrit or hemoglobin reading on the non-institutional claim.

**SHORT NAME:** HCTHGBRS

**LONG NAME:** LINE\_HCT\_HGB\_RSLT\_NUM

**TYPE:** NUM

**LENGTH:** 4

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** This variable became effective 9/1/2008 to comply with CR# 5699.

There is a variable to indicate the type of test - whether hematocrit or hemoglobin (variable called LINE\_HCT\_HGB\_TYPE\_CD).

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## LINE\_HCT\_HGB\_TYPE\_CD

**LABEL:** Hematocrit / Hemoglobin Test Type Code

**DESCRIPTION:** The type of test that was performed - hematocrit or hemoglobin.

**SHORT NAME:** HCTHGBTP

**LONG NAME:** LINE\_HCT\_HGB\_TYPE\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:** R1 = Hemoglobin Test  
R2 = Hematocrit Test

**COMMENT:** This variable became effective 9/1/2008 to comply with CR# 5699.

The laboratory value for the test is indicated in the hematocrit/hemoglobin test results field (variable called LINE\_HCT\_HGB\_RSLT\_NUM).

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## LINE\_ICD\_DGNS\_CD

**LABEL:** Line Diagnosis Code

**DESCRIPTION:** The code indicating the diagnosis supporting this line item procedure/service on the non-institutional claim.

**SHORT NAME:** LINE\_ICD\_DGNS\_CD

**LONG NAME:** LINE\_ICD\_DGNS\_CD

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## LINE\_ICD\_DGNS\_VRSN\_CD

**LABEL:** Line Diagnosis Code Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** LINE\_ICD\_DGNS\_VRSN\_CD

**LONG NAME:** LINE\_ICD\_DGNS\_VRSN\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9  
9 = ICD-9  
0 = ICD-10

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## LINE\_LAST\_EXPNS\_DT

**LABEL:** Line Last Expense Date

**DESCRIPTION:** The ending date (last expense) for the line item service on the non-institutional claim.

It is almost always the same as the line-level first expense date (variable called LINE\_1ST\_EXPNS\_DT); exception is for DME claims - where some services are billed in advance.

**SHORT NAME:** EXPNSDT2

**LONG NAME:** LINE\_LAST\_EXPNS\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## LINE\_NCH\_PMT\_AMT

**LABEL:** Line NCH Medicare Payment Amount

**DESCRIPTION:** Amount of payment made from the Medicare trust fund (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim.

**SHORT NAME:** LINEPMT

**LONG NAME:** LINE\_NCH\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## LINE\_NDC\_CD

**LABEL:** Line National Drug Code (NDC)

**DESCRIPTION:** On the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs.

This line item field was added as a placeholder on the Carrier claim.

**SHORT NAME:** LNNDCCD

**LONG NAME:** LINE\_NDC\_CD

**TYPE:** CHAR

**LENGTH:** 11

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## LINE\_NUM

**LABEL:** Claim Line Number

**DESCRIPTION:** This variable identifies an individual line number on a claim.

Each revenue center record or claim line has a sequential line number to distinguish distinct services that are submitted on the same claim.

All revenue center records or claim lines on a given claim have the same CLM\_ID.

**SHORT NAME:** LINE\_NUM

**LONG NAME:** LINE\_NUM

**TYPE:** NUM

**LENGTH:** 13

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** -

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## LINE\_OTHR\_APLD\_AMT1

**LABEL:** Line Other Applied Amount for 1<sup>st</sup> Code

**DESCRIPTION:** The field used to identify amounts that were used to adjust the amount payable when processing the line item.

**SHORT NAME:** LINE\_OTHR\_APLD\_AMT1

**LONG NAME:** LINE\_OTHR\_APLD\_AMT1

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** See the associated line other applied indicator code in the LINE\_OTHR\_APLD\_IND\_CD{#} field.

There are up to 7 of these line applied amount fields (LINE\_OTHR\_APLD\_AMT1 - LINE\_OTHR\_APLD\_AMT7).

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## LINE\_OTHR\_APLD\_AMT2

|                     |                                                                                                                                                                                                              |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Line Other Applied Amount for 2 <sup>nd</sup> Code                                                                                                                                                           |
| <b>DESCRIPTION:</b> | The field used to identify amounts that were used to adjust the amount payable when processing the line item.                                                                                                |
| <b>SHORT NAME:</b>  | LINE_OTHR_APLD_AMT2                                                                                                                                                                                          |
| <b>LONG NAME:</b>   | LINE_OTHR_APLD_AMT2                                                                                                                                                                                          |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                          |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                           |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                          |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                       |
| <b>COMMENT:</b>     | <p>See the associated line other applied indicator code in the LINE_OTHR_APLD_IND_CD{#} field.</p> <p>There are up to 7 of these line applied amount fields (LINE_OTHR_APLD_AMT1 - LINE_OTHR_APLD_AMT7).</p> |

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### LINE\_OTHR\_APLD\_AMT3

**LABEL:** Line Other Applied Amount for 3<sup>rd</sup> Code

**DESCRIPTION:** The field used to identify amounts that were used to adjust the amount payable when processing the line item.

**SHORT NAME:** LINE\_OTHR\_APLD\_AMT3

**LONG NAME:** LINE\_OTHR\_APLD\_AMT3

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** See the associated line other applied indicator code in the LINE\_OTHR\_APLD\_IND\_CD{#} field.

There are up to 7 of these line applied amount fields (LINE\_OTHR\_APLD\_AMT1 - LINE\_OTHR\_APLD\_AMT7).

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## LINE\_OTHR\_APLD\_AMT4

|                     |                                                                                                                                                                                                              |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Line Other Applied Amount for 4 <sup>th</sup> Code                                                                                                                                                           |
| <b>DESCRIPTION:</b> | The field used to identify amounts that were used to adjust the amount payable when processing the line item.                                                                                                |
| <b>SHORT NAME:</b>  | LINE_OTHR_APLD_AMT4                                                                                                                                                                                          |
| <b>LONG NAME:</b>   | LINE_OTHR_APLD_AMT4                                                                                                                                                                                          |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                          |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                           |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                          |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                       |
| <b>COMMENT:</b>     | <p>See the associated line other applied indicator code in the LINE_OTHR_APLD_IND_CD{#} field.</p> <p>There are up to 7 of these line applied amount fields (LINE_OTHR_APLD_AMT1 - LINE_OTHR_APLD_AMT7).</p> |

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## LINE\_OTHR\_APLD\_AMT5

**LABEL:** Line Other Applied Amount for 5<sup>th</sup> Code

**DESCRIPTION:** The field used to identify amounts that were used to adjust the amount payable when processing the line item.

**SHORT NAME:** LINE\_OTHR\_APLD\_AMT5

**LONG NAME:** LINE\_OTHR\_APLD\_AMT5

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** See the associated line other applied indicator code in the LINE\_OTHR\_APLD\_IND\_CD{#} field.

There are up to 7 of these line applied amount fields (LINE\_OTHR\_APLD\_AMT1 - LINE\_OTHR\_APLD\_AMT7).

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## LINE\_OTHR\_APLD\_AMT6

**LABEL:** Line Other Applied Amount for 6<sup>th</sup> Code

**DESCRIPTION:** The field used to identify amounts that were used to adjust the amount payable when processing the line item.

**SHORT NAME:** LINE\_OTHR\_APLD\_AMT6

**LONG NAME:** LINE\_OTHR\_APLD\_AMT6

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** See the associated line other applied indicator code in the LINE\_OTHR\_APLD\_IND\_CD{#} field.

There are up to 7 of these line applied amount fields (LINE\_OTHR\_APLD\_AMT1 - LINE\_OTHR\_APLD\_AMT7).

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## LINE\_OTHR\_APLD\_AMT7

|                     |                                                                                                                                                                                                              |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Line Other Applied Amount for 7 <sup>th</sup> Code                                                                                                                                                           |
| <b>DESCRIPTION:</b> | The field used to identify amounts that were used to adjust the amount payable when processing the line item.                                                                                                |
| <b>SHORT NAME:</b>  | LINE_OTHR_APLD_AMT7                                                                                                                                                                                          |
| <b>LONG NAME:</b>   | LINE_OTHR_APLD_AMT7                                                                                                                                                                                          |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                          |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                           |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                          |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                       |
| <b>COMMENT:</b>     | <p>See the associated line other applied indicator code in the LINE_OTHR_APLD_IND_CD{#} field.</p> <p>There are up to 7 of these line applied amount fields (LINE_OTHR_APLD_AMT1 - LINE_OTHR_APLD_AMT7).</p> |

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## LINE\_OTHR\_APLD\_IND\_CD1

**LABEL:** Line Other Applied Indicator 1<sup>st</sup> Code

**DESCRIPTION:** The code used to identify the reason the claim payment amount was adjusted during claims processing.

**SHORT NAME:** LINE\_OTHR\_APLD\_IND\_CD1

**LONG NAME:** LINE\_OTHR\_APLD\_IND\_CD1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Gramm-Rudman reduction required for services (03/03/1986-09/30/1986)
- B = Interest addition
- C = Positive rounding adjustment (due to line item distribution from total claim reimbursement amount)
- D = Negative rounding adjustment (due to line item distribution from total claim reimbursement amount)
- E = Primary Payer allowed charge
- F = Good cause
- G = PMD Demonstration Reduction
- H = Sequestration Reduction Amount
- I = eRX Negative Adjustment Reduction Amount
- J = ACO Payment Adjustment Amount (Pioneer ACO Reduction) - eff. 1/2014
- K = ASC Quality Reporting Payment Reduction (eff. 1/2014)
- L = (unknown value)
- M = Physician Quality Reporting System (PQRS) Negative Payment Adjustment – eff. 1/2015
- N = None
- O = Value Modifier Payment Adjustment – eff. 1/2015
- P = (unknown value)
- Q = Electronic Health Record (EHR) Negative Payment Adjustment – eff. 1/2015
- S = Prior Authorization Reduction (eff. 10/2016)

T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment (eff. 4/2017)

**COMMENT:** See the associated amounts in the LINE\_OTHR\_APLD\_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE\_OTHR\_APLD\_IND\_CD1 - LINE\_OTHR\_APLD\_IND\_CD7).

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## LINE\_OTHR\_APLD\_IND\_CD2

**LABEL:** Line Other Applied Indicator 2<sup>nd</sup> Code

**DESCRIPTION:** The code used to identify the reason the claim payment amount was adjusted during claims processing.

**SHORT NAME:** LINE\_OTHR\_APLD\_IND\_CD2

**LONG NAME:** LINE\_OTHR\_APLD\_IND\_CD2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Gramm-Rudman reduction required for services (03/03/1986-09/30/1986)
- B = Interest addition
- C = Positive rounding adjustment (due to line item distribution from total claim reimbursement amount)
- D = Negative rounding adjustment (due to line item distribution from total claim reimbursement amount)
- E = Primary Payer allowed charge
- F = Good cause
- G = PMD Demonstration Reduction
- H = Sequestration Reduction Amount
- I = eRX Negative Adjustment Reduction Amount
- J = ACO Payment Adjustment Amount (Pioneer ACO Reduction) - eff. 1/2014
- K = ASC Quality Reporting Payment Reduction (eff. 1/2014)
- L = (unknown value)
- M = Physician Quality Reporting System (PQRS) Negative Payment Adjustment – eff. 1/2015
- N = None
- O = Value Modifier Payment Adjustment – eff. 1/2015
- P = (unknown value)
- Q = Electronic Health Record (EHR) Negative Payment Adjustment – eff. 1/2015
- S = Prior Authorization Reduction (eff. 10/2016)

T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment (eff. 4/2017)

**COMMENT:** See the associated amounts in the LINE\_OTHR\_APLD\_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE\_OTHR\_APLD\_IND\_CD1 - LINE\_OTHR\_APLD\_IND\_CD7).

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### LINE\_OTHR\_APLD\_IND\_CD3

**LABEL:** Line Other Applied Indicator 3<sup>rd</sup> Code

**DESCRIPTION:** The code used to identify the reason the claim payment amount was adjusted during claims processing.

**SHORT NAME:** LINE\_OTHR\_APLD\_IND\_CD3

**LONG NAME:** LINE\_OTHR\_APLD\_IND\_CD3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Gramm-Rudman reduction required for services (03/03/1986-09/30/1986)
- B = Interest addition
- C = Positive rounding adjustment (due to line item distribution from total claim reimbursement amount)
- D = Negative rounding adjustment (due to line item distribution from total claim reimbursement amount)
- E = Primary Payer allowed charge
- F = Good cause
- G = PMD Demonstration Reduction
- H = Sequestration Reduction Amount
- I = eRX Negative Adjustment Reduction Amount
- J = ACO Payment Adjustment Amount (Pioneer ACO Reduction) - eff. 1/2014
- K = ASC Quality Reporting Payment Reduction (eff. 1/2014)
- L = (unknown value)
- M = Physician Quality Reporting System (PQRS) Negative Payment Adjustment – eff. 1/2015
- N = None
- O = Value Modifier Payment Adjustment – eff. 1/2015
- P = (unknown value)
- Q = Electronic Health Record (EHR) Negative Payment Adjustment – eff. 1/2015
- S = Prior Authorization Reduction (eff. 10/2016)

T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment (eff. 4/2017)

**COMMENT:** See the associated amounts in the LINE\_OTHR\_APLD\_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE\_OTHR\_APLD\_IND\_CD1 - LINE\_OTHR\_APLD\_IND\_CD7).

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#### LINE\_OTHR\_APLD\_IND\_CD4

**LABEL:** Line Other Applied Indicator 4<sup>th</sup> Code

**DESCRIPTION:** The code used to identify the reason the claim payment amount was adjusted during claims processing.

**SHORT NAME:** LINE\_OTHR\_APLD\_IND\_CD4

**LONG NAME:** LINE\_OTHR\_APLD\_IND\_CD4

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Gramm-Rudman reduction required for services (03/03/1986-09/30/1986)
- B = Interest addition
- C = Positive rounding adjustment (due to line item distribution from total claim reimbursement amount)
- D = Negative rounding adjustment (due to line item distribution from total claim reimbursement amount)
- E = Primary Payer allowed charge
- F = Good cause
- G = PMD Demonstration Reduction
- H = Sequestration Reduction Amount
- I = eRX Negative Adjustment Reduction Amount
- J = ACO Payment Adjustment Amount (Pioneer ACO Reduction) - eff. 1/2014
- K = ASC Quality Reporting Payment Reduction (eff. 1/2014)
- L = (unknown value)
- M = Physician Quality Reporting System (PQRS) Negative Payment Adjustment – eff. 1/2015
- N = None
- O = Value Modifier Payment Adjustment – eff. 1/2015
- P = (unknown value)
- Q = Electronic Health Record (EHR) Negative Payment Adjustment – eff. 1/2015
- S = Prior Authorization Reduction (eff. 10/2016)

T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment (eff. 4/2017)

**COMMENT:** See the associated amounts in the LINE\_OTHR\_APLD\_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE\_OTHR\_APLD\_IND\_CD1 - LINE\_OTHR\_APLD\_IND\_CD7).

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## LINE\_OTHR\_APLD\_IND\_CD5

**LABEL:** Line Other Applied Indicator 5<sup>th</sup> Code

**DESCRIPTION:** The code used to identify the reason the claim payment amount was adjusted during claims processing.

**SHORT NAME:** LINE\_OTHR\_APLD\_IND\_CD5

**LONG NAME:** LINE\_OTHR\_APLD\_IND\_CD5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Gramm-Rudman reduction required for services (03/03/1986-09/30/1986)
- B = Interest addition
- C = Positive rounding adjustment (due to line item distribution from total claim reimbursement amount)
- D = Negative rounding adjustment (due to line item distribution from total claim reimbursement amount)
- E = Primary Payer allowed charge
- F = Good cause
- G = PMD Demonstration Reduction
- H = Sequestration Reduction Amount
- I = eRX Negative Adjustment Reduction Amount
- J = ACO Payment Adjustment Amount (Pioneer ACO Reduction) - eff. 1/2014
- K = ASC Quality Reporting Payment Reduction (eff. 1/2014)
- L = (unknown value)
- M = Physician Quality Reporting System (PQRS) Negative Payment Adjustment – eff. 1/2015
- N = None
- O = Value Modifier Payment Adjustment – eff. 1/2015
- P = (unknown value)
- Q = Electronic Health Record (EHR) Negative Payment Adjustment – eff. 1/2015
- S = Prior Authorization Reduction (eff. 10/2016)

T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment (eff. 4/2017)

**COMMENT:** See the associated amounts in the LINE\_OTHR\_APLD\_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE\_OTHR\_APLD\_IND\_CD1 - LINE\_OTHR\_APLD\_IND\_CD7).

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## LINE\_OTHR\_APLD\_IND\_CD6

**LABEL:** Line Other Applied Indicator 6<sup>th</sup> Code

**DESCRIPTION:** The code used to identify the reason the claim payment amount was adjusted during claims processing.

**SHORT NAME:** LINE\_OTHR\_APLD\_IND\_CD6

**LONG NAME:** LINE\_OTHR\_APLD\_IND\_CD6

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Gramm-Rudman reduction required for services (03/03/1986-09/30/1986)
- B = Interest addition
- C = Positive rounding adjustment (due to line item distribution from total claim reimbursement amount)
- D = Negative rounding adjustment (due to line item distribution from total claim reimbursement amount)
- E = Primary Payer allowed charge
- F = Good cause
- G = PMD Demonstration Reduction
- H = Sequestration Reduction Amount
- I = eRX Negative Adjustment Reduction Amount
- J = ACO Payment Adjustment Amount (Pioneer ACO Reduction) - eff. 1/2014
- K = ASC Quality Reporting Payment Reduction (eff. 1/2014)
- L = (unknown value)
- M = Physician Quality Reporting System (PQRS) Negative Payment Adjustment – eff. 1/2015
- N = None
- O = Value Modifier Payment Adjustment – eff. 1/2015
- P = (unknown value)
- Q = Electronic Health Record (EHR) Negative Payment Adjustment – eff. 1/2015
- S = Prior Authorization Reduction (eff. 10/2016)

T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment (eff. 4/2017)

**COMMENT:** See the associated amounts in the LINE\_OTHR\_APLD\_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE\_OTHR\_APLD\_IND\_CD1 - LINE\_OTHR\_APLD\_IND\_CD7).

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## LINE\_OTHR\_APLD\_IND\_CD7

**LABEL:** Line Other Applied Indicator 7<sup>th</sup> Code

**DESCRIPTION:** The code used to identify the reason the claim payment amount was adjusted during claims processing.

**SHORT NAME:** LINE\_OTHR\_APLD\_IND\_CD7

**LONG NAME:** LINE\_OTHR\_APLD\_IND\_CD7

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Gramm-Rudman reduction required for services (03/03/1986-09/30/1986)
- B = Interest addition
- C = Positive rounding adjustment (due to line item distribution from total claim reimbursement amount)
- D = Negative rounding adjustment (due to line item distribution from total claim reimbursement amount)
- E = Primary Payer allowed charge
- F = Good cause
- G = PMD Demonstration Reduction
- H = Sequestration Reduction Amount
- I = eRX Negative Adjustment Reduction Amount
- J = ACO Payment Adjustment Amount (Pioneer ACO Reduction) - eff. 1/2014
- K = ASC Quality Reporting Payment Reduction (eff. 1/2014)
- L = (unknown value)
- M = Physician Quality Reporting System (PQRS) Negative Payment Adjustment – eff. 1/2015
- N = None
- O = Value Modifier Payment Adjustment – eff. 1/2015
- P = (unknown value)
- Q = Electronic Health Record (EHR) Negative Payment Adjustment – eff. 1/2015
- S = Prior Authorization Reduction (eff. 10/2016)

T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment (eff. 4/2017)

**COMMENT:** See the associated amounts in the LINE\_OTHR\_APLD\_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE\_OTHR\_APLD\_IND\_CD1 - LINE\_OTHR\_APLD\_IND\_CD7).

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## LINE\_PLACE\_OF\_SRVC\_CD

**LABEL:** Line Place of Service Code

**DESCRIPTION:** The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the non-institutional claim.

**SHORT NAME:** PLCSRVC

**LONG NAME:** LINE\_PLACE\_OF\_SRVC\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 01 = Pharmacy. A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
- 02 = Unassigned. N/A
- 03 = School. A facility whose primary purpose is education.
- 04 = Homeless Shelter. A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
- 05 = Indian Health Service - Free-standing Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
- 06 = Indian Health Service - Provider-based Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
- 07 = Tribal 638 - Free-standing Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
- 08 = Tribal 638 Provider-based Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

- 09 = Prison/Correctional Facility. A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
- 10 = Unassigned. N/A
- 11 = Office. Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
- 12 = Home. Location, other than a hospital or other facility, where the patient receives care in a private residence.
- 13 = Assisted Living Facility. Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
- 14 = Group Home. A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
- 15 = Mobile Unit. A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
- 16 = Temporary Lodging. A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
- 17 = Walk-in Retail Health Clinic. A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
- 18 = Unassigned. N/A
- 19 = Unassigned. N/A
- 20 = Urgent Care Facility. Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
- 21 = Inpatient Hospital. A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

- 22 = Outpatient Hospital. A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- 23 = Emergency Room – Hospital. A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
- 24 = Ambulatory Surgical Center. A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
- 25 = Birthing Center. A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
- 26 = Military Treatment Facility. A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
- 27 = Unassigned. N/A
- 28 = Unassigned. N/A
- 29 = Unassigned. N/A
- 30 = Unassigned. N/A
- 31 = Skilled Nursing Facility. A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
- 32 = Nursing Facility. A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
- 33 = Custodial Care Facility. A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
- 34 = Hospice. A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
- 35-40 = Unassigned. N/A
- 41 = Ambulance - Land. A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

- 42 = Ambulance – Air or Water. An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
- 43-48 = Unassigned. N/A
- 49 = Independent Clinic. A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
- 50 = Fed Qualified Health Ctr. A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
- 51 = Inpatient Psych Facility. A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
- 52 = Psychiatric Facility - Partial Hospitalization. A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
- 53 = Community Mental Health Ctr. A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
- 54 = Intermediate Care/Mentally Retarded Facility. A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
- 55 = Residential Substance Abuse Treatment Facility. A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
- 56 = Psychiatric Residential Treatment Center. A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

- 57 = Non-residential Substance Abuse Treatment Facility. A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
- 58 = Unassigned. N/A
- 59 = Unassigned. N/A
- 60 = Mass Immunization Center. A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
- 61 = Comprehensive Inpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
- 62 = Comprehensive Outpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
- 63 = Unassigned. N/A
- 64 = Unassigned. N/A
- 65 = End-Stage Renal Disease Treatment Facility. A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
- 66-70 = Unassigned. N/A
- 71 = Public Health Clinic. A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
- 72 = Rural Health Clinic. A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
- 73-80 = Unassigned. N/A
- 81 = Independent Laboratory. A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
- 82-98 = Unassigned. N/A

99 = Other Place of Service. Other place of service not identified above.

**COMMENT:** -

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## LINE\_PMT\_80\_100\_CD

**LABEL:** Line Payment 80% / 100% Code

**DESCRIPTION:** The code indicating that the amount shown in the payment field on the non-institutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.

**SHORT NAME:** PMTINDSW

**LONG NAME:** LINE\_PMT\_80\_100\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|   |   |                                   |
|---|---|-----------------------------------|
| 0 | = | 80%                               |
| 1 | = | 100%                              |
| 3 | = | 100% Limitation of liability only |
| 4 | = | 75% Reimbursement                 |

**COMMENT:** -

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## LINE\_PRCSG\_IND\_CD

**LABEL:** Line Processing Indicator Code

**DESCRIPTION:** The code on a non-institutional claim indicating to whom payment was made or if the claim was denied.

**SHORT NAME:** PRCNGIND

**LONG NAME:** LINE\_PRCSG\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- A = Allowed
- B = Benefits exhausted
- C = Non-covered care
- D = Denied (from BMAD)
- I = Invalid data
- L = CLIA
- M = Multiple submittal--duplicate line item
- N = Medically unnecessary
- O = Other
- P = Physician ownership denial
- Q = MSP cost avoided (contractor #88888) - voluntary agreement
- R = Reprocessed--adjustments based on subsequent reprocessing of claim
- S = Secondary payer
- T = MSP cost avoided - IEQ contractor
- U = MSP cost avoided - HMO rate cell adjustment
- V = MSP cost avoided - litigation settlement
- X = MSP cost avoided - generic
- Y = MSP cost avoided - IRS/SSA data match project
- Z = Bundled test, no payment
- 00 = MSP cost avoided - COB Contractor
- 12 = MSP cost avoided - BC/BS Voluntary Agreements
- 13 = MSP cost avoided - Office of Personnel Management
- 14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
- 15 = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)
- 16 = MSP cost avoided - Liability Insurer VDSA (eff.4/2006)
- 17 = MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006)
- 18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff.4/2006)
- 21 = MSP cost avoided - MIR Group Health Plan (eff.1/2009)
- 22 = MSP cost avoided - MIR non-Group Health Plan (eff.1/2009)

- 25 = MSP cost avoided - Recovery Audit Contractor - California (eff.10/2005)
- 26 = MSP cost avoided - Recovery Audit Contractor - Florida (eff.10/2005)

Effective 4/1/02, the Line Processing Indicator code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

- ! MSP cost avoided - COB Contractor ('00' 2-byte code)
- @ MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code)
- # MSP cost avoided - Office of Personnel Management ('13' 2-byte code)
- \$ MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code)
- \* MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006)
- ( MSP cost avoided - Liability Insurer VDSA ('16' 2-byte code) (eff. 4/2006)
- ) MSP cost avoided - No-Fault Insurer VDSA ('17' 2-byte code) (eff. 4/2006)
- + MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement ('18' 2-byte code) (eff. 4/2006)
- < MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009)
- > MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009)
- % MSP cost avoided - Recovery Audit Contractor - California ('25' 2-byte code) (eff. 10/2005)
- & MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)

**COMMENT:** -

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## LINE\_PRMRY\_ALOWD\_CHRG\_AMT

**LABEL:** Line Primary Payer Allowed Charge Amount

**DESCRIPTION:** The primary payer allowed charge amount for the line item service on the non-institutional claim.

If there is a primary payer other than Medicare, there may be an allowed payment for the provider; if so, this field is populated.

**SHORT NAME:** PRPYALLOW

**LONG NAME:** LINE\_PRMRY\_ALOWD\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## LINE\_PRVDR\_PMT\_AMT

**LABEL:** Line Provider Payment Amount

**DESCRIPTION:** The payment made by Medicare to the provider for the line item service on the non-institutional claim. Additional payments may have been made to the provider - including beneficiary deductible and coinsurance amounts and/or other primary payer amounts.

**SHORT NAME:** LPRVPMT

**LONG NAME:** LINE\_PRVDR\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## LINE\_SBMTD\_CHRG\_AMT

**LABEL:** Line Submitted Charge Amount

**DESCRIPTION:** The amount of submitted charges for the line item service on the non-institutional claim.

Providers' submitted charges often differ from the amount they were eventually paid - either from Medicare, the beneficiary (through deductible or coinsurance amounts) or third party payers.

**SHORT NAME:** LSBMTCHG

**LONG NAME:** LINE\_SBMTD\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## LINE\_SERVICE\_DEDUCTIBLE

**LABEL:** Line Service Deductible Indicator Switch

**DESCRIPTION:** Switch indicating whether or not the line item service on the non-institutional claim is subject to a deductible.

**SHORT NAME:** DED\_SW

**LONG NAME:** LINE\_SERVICE\_DEDUCTIBLE

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** 0 = Service Subject to Deductible  
1 = Service Not Subject to Deductible

**COMMENT:** -

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## LINE\_SRVC\_CNT

**LABEL:** Line Service Count

**DESCRIPTION:** The count of the total number of services processed for the line item on the non-institutional claim.

**SHORT NAME:** SRVC\_CNT

**LONG NAME:** LINE\_SRVC\_CNT

**TYPE:** NUM

**LENGTH:** 4

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## NCH\_ACTV\_OR\_CVRD\_LVL\_CARE\_THRU

**LABEL:** NCH Active or Covered Level Care Thru Date

**DESCRIPTION:** The date on a claim for which the covered level of care ended in a general hospital or the active care ended in a psychiatric/tuberculosis hospital.

**SHORT NAME:** CARETHRU

**LONG NAME:** NCH\_ACTV\_OR\_CVRD\_LVL\_CARE\_THRU

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** This variable is derived, using the occurrence code (variable called CLM\_RLT\_OCRNC\_CD), when the value is 22. When this code value is present the date is populated using the CLM\_RLT\_OCRNC\_DT.

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## NCH\_BENE\_BLOOD\_DDCTBL\_LBLTY\_AM

**LABEL:** NCH Beneficiary Blood Deductible Liability Amount

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

A blood deductible amount applies to the first 3 pints of blood (or equivalent units; applies only to whole blood or packed red cells - not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

**SHORT NAME:** BLDDDEDAM

**LONG NAME:** NCH\_BENE\_BLOOD\_DDCTBL\_LBLTY\_AM

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA PROCESS

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the blood deductible.

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## NCH\_BENE\_DSCHRG\_DT

**LABEL:** NCH Beneficiary Discharge Date

**DESCRIPTION:** On an inpatient or Home Health claim, the date the beneficiary was discharged from the facility, or died.

Date matches the "thru" date on the claim (CLM\_THRU\_DT). When there is a discharge date, the discharge status code (PTNT\_DSCHRG\_STUS\_CD) indicates the final disposition of the patient after discharge.

**SHORT NAME:** DSCHRGDT

**LONG NAME:** NCH\_BENE\_DSCHRG\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** -

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## NCH\_BENE\_IP\_DDCTBL\_AMT

**LABEL:** NCH Beneficiary Inpatient (or other Part A) Deductible Amount

**DESCRIPTION:** The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.

Under Part A, the deductible applies only to inpatient hospital care (whether in an acute care facility, Inpatient psychiatric facility [IPF], inpatient rehabilitation facility [IRF], or long term care hospital [LTCH]) and is charged only at the beginning of each benefit period, which is similar to an episode of illness.

This variable is null/missing for skilled nursing facility (SNF), home health, and hospice claims.

**SHORT NAME:** DED\_AMT

**LONG NAME:** NCH\_BENE\_IP\_DDCTBL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website.

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## NCH\_BENE\_MDCR\_BNFTS\_EXHTD\_DT\_I

**LABEL:** NCH Beneficiary Medicare Benefits Exhausted Date

**DESCRIPTION:** The last date for which the beneficiary has Medicare coverage.

This is completed only where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim.

**SHORT NAME:** EXHST\_DT

**LONG NAME:** NCH\_BENE\_MDCR\_BNFTS\_EXHTD\_DT\_I

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** Derived from: CLM\_RLT\_OCRNC\_CD and CLM\_RLT\_OCRNC\_DT

Derivation rules: Based on the presence of occurrence code A3, B3 or C3 move the related occurrence date to NCH\_MDCR\_BNFT\_EXHST\_DT.

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## NCH\_BENE\_PTA\_COINSRNC\_LBLTY\_AMT

**LABEL:** NCH Beneficiary Part A Coinsurance Liability Amount

**DESCRIPTION:** The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim.

Under Part A, beneficiaries pay coinsurance starting with the 61st day of an inpatient hospital stay (one daily amount for days 61-90, and a higher daily amount for any days after that, which count towards a beneficiary's 60 lifetime reserve days) or the 21st day of a skilled nursing facility (SNF) stay (a daily amount for days 21-100, after which SNF coverage ends).

This variable is null/missing for home health and hospice claims.

**SHORT NAME:** COIN\_AMT

**LONG NAME:** NCH\_BENE\_PTA\_COINSRNC\_LBLTY\_AM

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website.

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## **NCH\_BENE\_PTB\_COINSRNC\_AMT**

**LABEL:** NCH Beneficiary Part B Coinsurance Amount

**DESCRIPTION:** The amount of money for which the intermediary has determined that the beneficiary is liable for Part B coinsurance on the institutional claim.

**SHORT NAME:** PTB\_COIN

**LONG NAME:** NCH\_BENE\_PTB\_COINSRNC\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA PROCESS

**VALUES:** XXX.XX

**COMMENT:** Derivation Rules: If value codes (variable called CLM\_VAL\_CD) = A2, B2 or C2, then the related value amount (variable called CLM\_VAL\_AMT ) is output to this field.

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## NCH\_BENE\_PTBDUCTBL\_AMT

**LABEL:** NCH Beneficiary Part B Deductible Amount

**DESCRIPTION:** The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B cash deductible on the claim.

**SHORT NAME:** PTB\_DED

**LONG NAME:** NCH\_BENE\_PTBDUCTBL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA PROCESS

**VALUES:** XXX.XX

**COMMENT:** Derivation Rules: If value codes (variable called CLM\_VAL\_CD) = A1, B1 or C1, then the related value amount (variable called CLM\_VAL\_AMT ) is output to this field.

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## NCH\_BLOOD\_PNTS\_FRNSHD\_QTY

**LABEL:** NCH Blood Pints Furnished Quantity

**DESCRIPTION:** Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).

**SHORT NAME:** BLDFRNSH

**LONG NAME:** NCH\_BLOOD\_PNTS\_FRNSHD\_QTY

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## NCH\_CARR\_CLM\_ALOWD\_AMT

**LABEL:** NCH Carrier Claim Allowed Charge Amount (sum of all line-level allowed charges)

**DESCRIPTION:** The total allowed charges on the claim (the sum of line item allowed charges).

**SHORT NAME:** ALLOWCHRG

**LONG NAME:** NCH\_CARR\_CLM\_ALOWD\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** Sum of all the line LINE\_NCH\_PMT\_AMT values for the claim.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## NCH\_CARR\_CLM\_SBMTD\_CHRG\_AMT

**LABEL:** NCH Carrier Claim Submitted Charge Amount (sum of all line-level submitted charges)

**DESCRIPTION:** The total submitted charges on the claim (sum of all line-level submitted charges, variable called LINE\_SBMTD\_CHRG\_AMT)

**SHORT NAME:** SBMTCHRG

**LONG NAME:** NCH\_CARR\_CLM\_SBMTD\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** The charges the provider submits may be different than the amount that Medicare or a secondary payer will allow for the claim - and this amount is also different than the actual Medicare or beneficiary paid amounts.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>)

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## NCH\_CLM\_BENE\_PMT\_AMT

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | NCH Claim Payment Amount to Beneficiary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>DESCRIPTION:</b> | The total payments made to the beneficiary for this claim (sum of all line-level payments to beneficiary, variable called LINE_BENE_PMT_AMT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>SHORT NAME:</b>  | BENE_PMT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>LONG NAME:</b>   | NCH_CLM_BENE_PMT_AMT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>SOURCE:</b>      | NCH QA Process                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>COMMENT:</b>     | <p>This variable is populated if, for example, a beneficiary pays for a service that should have been Medicare-covered.</p> <p>The beneficiary can be refunded the payment.</p> <p>Costs to that beneficiaries are liable for are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles and coinsurance amounts.</p> <p>Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" (see: <a href="http://www.medpac.gov/payment_basics.cfm">http://www.medpac.gov/payment_basics.cfm</a>).</p> <p>Also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see the list of MLN publications at: <a href="http://www.cms.gov/Outreach-and-ducation/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html">http://www.cms.gov/Outreach-and-ducation/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html</a>)</p> |

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## NCH\_CLM\_PRVDT\_PMT\_AMT

**LABEL:** NCH Claim Provider Payment Amount

**DESCRIPTION:** The total payments made to the provider for this claim (sum of line item provider payment amounts (variable called LINE\_PRVDR\_PMT\_AMT)).

**SHORT NAME:** PROV\_PMT

**LONG NAME:** NCH\_CLM\_PRVDR\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see [http://www.medpac.gov/payment\\_basics.cfm](http://www.medpac.gov/payment_basics.cfm)).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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## NCH\_CLM\_TYPE\_CD

**LABEL:** NCH Claim Type Code

**DESCRIPTION:** The type of claim that was submitted. There are different claim types for each major category of health care provider.

**SHORT NAME:** CLM\_TYPE

**LONG NAME:** NCH\_CLM\_TYPE\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

|      |                                                                                                     |
|------|-----------------------------------------------------------------------------------------------------|
| 10 = | Home Health Agency (HHA) claim                                                                      |
| 20 = | Non swing bed Skilled Nursing Facility (SNF) claim                                                  |
| 30 = | Swing bed SNF claim                                                                                 |
| 40 = | Hospital Outpatient claim                                                                           |
| 50 = | Hospice claim                                                                                       |
| 60 = | Inpatient claim                                                                                     |
| 71 = | Local carrier non-durable medical equipment,<br>prosthetics, orthotics, and supplies (DMEPOS) claim |
| 72 = | Local carrier DMEPOS claim                                                                          |
| 81 = | Durable medical equipment regional carrier (DMERC);<br>non-DMEPOS claim                             |
| 82 = | DMERC; DMEPOS claim                                                                                 |

**COMMENT:** This variable may not always indicate the type of service performed; for example, when the claim type code = 60 (inpatient), the services may actually be for post-acute care. Additional information regarding the type of service on the claim can be found in a CCW Technical Guidance document entitled: "Getting Started with Medicare data"

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## NCH\_DRG\_OUTLIER\_APRVD\_PMT\_AMT

**LABEL:** NCH DRG Outlier Approved Payment Amount

**DESCRIPTION:** On an institutional claim, the additional payment amount approved by the Quality Improvement Organization due to an outlier situation for a beneficiary's stay under the prospective payment system (PPS), which has been classified into a specific diagnosis related group (DRG).

This variable will typically include the total outlier payment amount, if any, for the claim.

**SHORT NAME:** OUTLRPMT

**LONG NAME:** NCH\_DRG\_OUTLIER\_APRVD\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** -

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## NCH\_IP\_NCVRD\_CHRG\_AMT

**LABEL:** NCH Inpatient(or other Part A) Non-covered Charge Amount

**DESCRIPTION:** The non-covered charges for all accommodations and services, reported on an inpatient claim (used for internal NCHMQA editing purposes).

**SHORT NAME:** NCCHGAMT

**LONG NAME:** NCH\_IP\_NCVRD\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** DERIVED FROM:

- REV\_CNTR\_CD

- REV\_CNTR\_NCVR\_CHRG\_AMT.

Derivation Rules: Based on the presence of revenue center code equal to 0001, move the related non-covered charge amount to NCH\_IP\_NCOV\_CHRG\_AMT.

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## **NCH\_IP\_TOT\_DDCTN\_AMT**

**LABEL:** NCH Inpatient (or other Part A) Total Deductible/Coinsurance Amount

**DESCRIPTION:** The total of all Part A and blood deductibles and coinsurance amounts on the claim.

**SHORT NAME:** TDEDAMT

**LONG NAME:** NCH\_IP\_TOT\_DDCTN\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** Derivation Rules: Accumulate the value amounts (from field called CLM\_VAL\_AMT) associated with value codes (CLM\_VAL\_CD) equal to 06, 08 thru 11 and A1, B1 or C1 and output to this field.

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## NCH\_NEAR\_LINE\_REC\_IDENT\_CD

**LABEL:** NCH Near Line Record Identification Code (RIC)

**DESCRIPTION:** A code defining the type of claim record being processed.

**SHORT NAME:** RIC\_CD

**LONG NAME:** NCH\_NEAR\_LINE\_REC\_IDENT\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- M = Part B DMEPOS claim record (processed by DME Regional Carrier)
- O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
- U = Both Part A and B institutional home health agency (HHA) claim records
- V = Part A institutional claim record (inpatient [IP], skilled nursing facility [SNF], hospice [HOS], or home health agency [HHA])
- W = Part B institutional claim record (outpatient [HOP], HHA)

**COMMENT:** -

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## NCH\_PRMRY\_PYR\_CD

**LABEL:** NCH Primary Payer Code (if not Medicare)

**DESCRIPTION:** 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.

The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.

**SHORT NAME:** PRPAY\_CD

**LONG NAME:** NCH\_PRMRY\_PYR\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|                   |                                                                                                     |
|-------------------|-----------------------------------------------------------------------------------------------------|
| A =               | Employer group health plan (EGHP) insurance for an aged beneficiary                                 |
| B =               | EGHP insurance for an end-stage renal disease (ESRD) beneficiary                                    |
| C =               | Conditional payment by Medicare; future reimbursement from the Public Health Service (PHS) expected |
| D =               | No fault automobile insurance                                                                       |
| E =               | Worker's compensation (WC)                                                                          |
| F =               | Public Health Service (PHS) or other Federal agency (other than VA)                                 |
| G =               | Working disabled beneficiary under age 65 with a local government health plan (LGHP)                |
| H =               | Black lung (BL) program                                                                             |
| I =               | Department of Veteran's Affairs                                                                     |
| L =               | Any liability insurance                                                                             |
| M =               | Override EGHP - Medicare is primary payer                                                           |
| N =               | Override non-EGHP - Medicare is primary payer                                                       |
| Blank / missing = | No other primary payer                                                                              |

**COMMENT:** -

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## NCH\_PROFNL\_CMPNT\_CHRG\_AMT

**LABEL:** Professional Component Charge Amount

**DESCRIPTION:** This field is the amount of physician and other professional charges covered under Medicare Part B.

**SHORT NAME:** PCCHGAMT

**LONG NAME:** NCH\_PROFNL\_CMPNT\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** This variable is not populated for Home Health or Hospice claims.

This field is used for CMS editing purposes and other internal processes (e.g. if computing interim payments, then these charges are deducted).

The source of information for this field for institutional claims is the CLM\_VAL\_AMT (when the code = 04 or 05, it indicates a professional component charge amount).

For Outpatient claims, this information is from the revenue center codes (when the code=096\*, 097\* or 098\*, then the REV\_CNTR\_TOT\_CHRG\_AMT indicates a professional component charge amount).

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## NCH\_PTNT\_STUS\_IND\_CD

**LABEL:** NCH Patient Status Indicator Code

**DESCRIPTION:** This variable is a recoded version of the discharge status code (variable called PTNT\_DSCHRG\_STUS\_CD).

**SHORT NAME:** PTNTSTUS

**LONG NAME:** NCH\_PTNT\_STUS\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH QA Process

**VALUES:** A = Discharged  
B = Died  
C = Still a patient

**COMMENT:** -

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## NCH\_QLFYD\_STAY\_FROM\_DT

**LABEL:** NCH Qualified Stay From Date

**DESCRIPTION:** The beginning date of the beneficiary's qualifying Medicare stay.

For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization of 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' (transfer from critical access hospital), or at least three days in a row if the source of admission is other than 'A'.

**SHORT NAME:** QLFYFROM

**LONG NAME:** NCH\_QLFYD\_STAY\_FROM\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** Derivation Rules: Based on the presence of the occurrence span code (variable called CLM\_OCRNC\_SPAN\_CD) 70. When this code value is present the date is populated using the CLM\_OCRNC\_SPAN\_FROM\_DT.

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## NCH\_QLFYD\_STAY\_THRU\_DT

**LABEL:** NCH Qualified Stay Through Date

**DESCRIPTION:** The ending date of the beneficiary's qualifying Medicare stay.

For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization of 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' (transfer from critical access hospital), or at least three days in a row if the source of admission is other than 'A'.

**SHORT NAME:** QLFYTHRU

**LONG NAME:** NCH\_QLFYD\_STAY\_THRU\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** Derivation Rules: Based on the presence of the occurrence span code (variable called CLM\_OCRNC\_SPAN\_CD) 70. When this code value is present the date is populated using the CLM\_OCRNC\_SPAN\_THRU\_DT.

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## NCH\_VRFD\_NCVRD\_STAY\_FROM\_DT

**LABEL:** NCH Verified Non-covered Stay From Date

**DESCRIPTION:** The beginning date of the beneficiary's Non-covered stay.

Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive.

For some beneficiaries, all days in one of these settings may not be covered by Medicare.

**SHORT NAME:** NCOVFROM

**LONG NAME:** NCH\_VRFD\_NCVRD\_STAY\_FROM\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** Derivation Rules: Based on the presence of the occurrence span code (variable called CLM\_SPAN\_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM\_SPAN\_FROM\_DT.

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## NCH\_VRFD\_NCVRD\_STAY\_THRU\_DT

**LABEL:** NCH Verified Non-covered Stay Through Date

**DESCRIPTION:** The ending date of the beneficiary's non-covered stay.

Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive.

For some beneficiaries, all days in one of these settings may not be covered by Medicare.

**SHORT NAME:** NCOVTHRU

**LONG NAME:** NCH\_VRFD\_NCVRD\_STAY\_THRU\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** -

**COMMENT:** Derivation Rules: Based on the presence of the occurrence span code (variable called CLM\_SPAN\_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM\_SPAN\_THRU\_DT.

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## NCH\_WKLY\_PROC\_DT

**LABEL:** NCH Weekly Claim Processing Date

**DESCRIPTION:** The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

**SHORT NAME:** WKLY\_DT

**LONG NAME:** NCH\_WKLY\_PROC\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## OP\_PHYSN\_NPI

**LABEL:** Claim Operating Physician NPI Number

**DESCRIPTION:** On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the physician with the primary responsibility for performing the surgical procedure(s).

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** OP\_NPI

**LONG NAME:** OP\_PHYSN\_NPI

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no new UPINs (legacy numbers) will be generated for new physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

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## OP\_PHYSN\_SPCLTY\_CD

**LABEL:** Claim Operating Physician Specialty Code

**DESCRIPTION:** The code used to identify the CMS specialty code corresponding to the operating physician. The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physicians is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.

**SHORT NAME:** OP\_PHYSN\_SPCLTY\_CD

**LONG NAME:** OP\_PHYSN\_SPCLTY\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/03)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech / language pathology
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = General Psychiatry
- 28 = Colorectal surgery (formerly proctology)

- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation
- 32 = Anesthesiologist Assistants (eff. 4/1/03--previously grouped with Certified Registered Nurse Anesthetists (CRNA))
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometrist
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/03)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
- 47 = Independent Diagnostic Testing Facility (IDTF)
- 48 = Podiatry
- 49 = Ambulatory surgical center (formerly miscellaneous)
- 50 = Nurse practitioner
- 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
- 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 54 = Medical supply company for DMERC (and not included in 51-53)
- 55 = Individual certified orthoptist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-orthotist
- 58 = Medical supply company with registered pharmacist
- 59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
- 60 = Public health or welfare agencies (federal, state, and local)
- 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
- 62 = Psychologist (billing independently)
- 63 = Portable X-ray supplier
- 64 = Audiologist (billing independently)

- 65 = Physical therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 66 = Rheumatology
- 67 = Occupational therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 68 = Clinical psychologist
- 69 = Clinical laboratory (billing independently)
- 70 = Multispecialty clinic or group practice
- 71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
- 72 = Pain Management (eff. 1/1/02)
- 73 = Mass Immunization Roster Biller
- 74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF))
- 75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs -- eff. 4/1/03)
- 76 = Peripheral vascular disease
- 77 = Vascular surgery
- 78 = Cardiac surgery
- 79 = Addiction medicine
- 80 = Licensed clinical social worker
- 81 = Critical care (intensivists)
- 82 = Hematology
- 83 = Hematology/oncology
- 84 = Preventive medicine
- 85 = Maxillofacial surgery
- 86 = Neuropsychiatry
- 87 = All other suppliers (e.g. drug and department stores)
- 88 = Unknown supplier/provider specialty
- 89 = Certified clinical nurse specialist
- 90 = Medical oncology
- 91 = Surgical oncology
- 92 = Radiation oncology
- 93 = Emergency medicine
- 94 = Interventional radiology
- 95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory
- 96 = Optician
- 97 = Physician assistant
- 98 = Gynecologist/oncologist
- 99 = Unknown physician specialty
- A0 = Hospital (DMERCs only)
- A1 = SNF (DMERCs only)
- A2 = Intermediate care nursing facility (DMERCs only)
- A3 = Nursing facility, other (DMERCs only)

A4 = Home Health Agency (DMERCs only)  
A5 = Pharmacy (DMERC)  
A6 = Medical supply company with respiratory therapist (DMERCs only)  
A7 = Department store (DMERC)  
A8 = Grocery store (DMERC)  
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities, eff. 1/2005)  
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)  
B2 = Pedorthic Personnel (eff. 10/2/07)  
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/07)  
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/07)  
B5 = Ocularist  
C0 = Sleep medicine  
C1 = Centralized flu  
C2 = Indirect payment procedure  
C3 = Interventional cardiology  
C5 = Dentist (eff. 7/2016)

**COMMENT:** -

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## OP\_PHYSN\_UPIN

**LABEL:** Claim Operating Physician UPIN Number

**DESCRIPTION:** 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.

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** OP\_UPIN

**LONG NAME:** OP\_PHYSN\_UPIN

**TYPE:** CHAR

**LENGTH:** 6

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## ORG\_NPI\_NUM

**LABEL:** Organization (or group) NPI Number

**DESCRIPTION:** The National Provider Identifier (NPI) of the organization or group practice.

**SHORT NAME:** ORGNPINM

**LONG NAME:** ORG\_NPI\_NUM

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** On an institutional claim, this is the NPI number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

On the carrier claim, this is line-level information regarding the performing physician (Short Name = PRGRPNPI); it is the NPI of the group practice, where the performing physician is part of that group.

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## OT\_PHYSN\_NPI

**LABEL:** Claim Other Physician NPI Number

**DESCRIPTION:** On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** OT\_NPI

**LONG NAME:** OT\_PHYSN\_NPI

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no new UPINs (legacy numbers) will be generated for new physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

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## OT\_PHYSN\_SPCLTY\_CD

**LABEL:** Claim Other Physician Specialty Code

**DESCRIPTION:** The code used to identify the CMS specialty code corresponding to the other physician.

**SHORT NAME:** OT\_PHYSN\_SPCLTY\_CD

**LONG NAME:** OT\_PHYSN\_SPCLTY\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/03)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech / language pathology
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = General Psychiatry
- 28 = Colorectal surgery (formerly proctology)
- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation

- 32 = Anesthesiologist Assistants (eff. 4/1/03—previously grouped with Certified Registered Nurse Anesthetists (CRNA))
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometrist
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/03)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
- 47 = Independent Diagnostic Testing Facility (IDTF)
- 48 = Podiatry
- 49 = Ambulatory surgical center (formerly miscellaneous)
- 50 = Nurse practitioner
- 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
- 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 54 = Medical supply company for DMERC (and not included in 51-53)
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-orthotist
- 58 = Medical supply company with registered pharmacist
- 59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
- 60 = Public health or welfare agencies (federal, state, and local)
- 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
- 62 = Psychologist (billing independently)
- 63 = Portable X-ray supplier
- 64 = Audiologist (billing independently)
- 65 = Physical therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 66 = Rheumatology

- 67 = Occupational therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 68 = Clinical psychologist
- 69 = Clinical laboratory (billing independently)
- 70 = Multispecialty clinic or group practice
- 71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
- 72 = Pain Management (eff. 1/1/02)
- 73 = Mass Immunization Roster Biller
- 74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
- 75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs -- eff. 4/1/03)
- 76 = Peripheral vascular disease
- 77 = Vascular surgery
- 78 = Cardiac surgery
- 79 = Addiction medicine
- 80 = Licensed clinical social worker
- 81 = Critical care (intensivists)
- 82 = Hematology
- 83 = Hematology/oncology
- 84 = Preventive medicine
- 85 = Maxillofacial surgery
- 86 = Neuropsychiatry
- 87 = All other suppliers (e.g. drug and department stores)
- 88 = Unknown supplier/provider specialty
- 89 = Certified clinical nurse specialist
- 90 = Medical oncology
- 91 = Surgical oncology
- 92 = Radiation oncology
- 93 = Emergency medicine
- 94 = Interventional radiology
- 95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory
- 96 = Optician
- 97 = Physician assistant
- 98 = Gynecologist/oncologist
- 99 = Unknown physician specialty
- A0 = Hospital (DMERCs only)
- A1 = SNF (DMERCs only)
- A2 = Intermediate care nursing facility (DMERCs only)
- A3 = Nursing facility, other (DMERCs only)
- A4 = Home Health Agency (DMERCs only)
- A5 = Pharmacy (DMERC)
- A6 = Medical supply company with respiratory therapist (DMERCs only)

A7 = Department store (DMERC)  
A8 = Grocery store (DMERC)  
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities, eff. 1/2005)  
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)  
B2 = Pedorthic Personnel (eff. 10/2/07)  
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/07)  
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/07)  
B5 = Ocularist  
C0 = Sleep medicine  
C1 = Centralized flu  
C2 = Indirect payment procedure  
C3 = Interventional cardiology  
C5 = Dentist (eff. 7/2016)

**COMMENT:** The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physician is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.

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## OT\_PHYSN\_UPIN

**LABEL:** Claim Other Physician UPIN Number

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

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** OT\_UPIN

**LONG NAME:** OT\_PHYSN\_UPIN

**TYPE:** CHAR

**LENGTH:** 6

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PHYSN\_ZIP\_CD

**LABEL:** Line Place of Service (POS) Physician Zip Code

**DESCRIPTION:** The 9-digit zip code for the primary practice/business location of the physician receiving the payment or other transfer of value.

**SHORT NAME:** PHYSN\_ZIP\_CD

**LONG NAME:** PHYSN\_ZIP\_CD

**TYPE:** CHAR

**LENGTH:** 15

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PPS\_STD\_VAL\_PYMT\_AMT

**LABEL:** Standard Payment Amount

**DESCRIPTION:** This amount identifies the standardized Medicare payment amount.

**SHORT NAME:** PPS\_STD\_VAL\_PYMT\_AMT

**LONG NAME:** PPS\_STD\_VAL\_PYMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This is the standardized amount as determined by PRICER software output. This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the hospitals.

This field is new in October 2014. This field only applies to Inpatient claims.

Note that an additional field is available that further adjusts the standard Medicare Payment amount by applying additional standardization requirements (e.g. sequestration).

Refer to variable called the final standardized amount (FINL\_STD\_AMT).

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## PRCDR\_DT1

**LABEL:** Claim Procedure Code I Date

**DESCRIPTION:** The date on which the principal procedure was performed. The date associated with the procedure identified in ICD\_PRCDR\_CD1.

**SHORT NAME:** PRCDR\_DT1

**LONG NAME:** PRCDR\_DT1

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT2

**LABEL:** Claim Procedure Code II Date

**DESCRIPTION:** The date on which the 2<sup>nd</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT2

**LONG NAME:** PRCDR\_DT2

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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### PRCDR\_DT3

**LABEL:** Claim Procedure Code III Date

**DESCRIPTION:** The date on which the 3<sup>rd</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT3

**LONG NAME:** PRCDR\_DT3

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT4

**LABEL:** Claim Procedure Code IV Date

**DESCRIPTION:** The date on which the 4<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT4

**LONG NAME:** PRCDR\_DT4

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT5

**LABEL:** Claim Procedure Code V Date

**DESCRIPTION:** The date on which the 5<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT5

**LONG NAME:** PRCDR\_DT5

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT6

**LABEL:** Claim Procedure Code VI Date

**DESCRIPTION:** The date on which the 6<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT6

**LONG NAME:** PRCDR\_DT6

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT7

**LABEL:** Claim Procedure Code VII Date

**DESCRIPTION:** The date on which the 7<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT7

**LONG NAME:** PRCDR\_DT7

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT8

**LABEL:** Claim Procedure Code VIII Date

**DESCRIPTION:** The date on which the 8<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT8

**LONG NAME:** PRCDR\_DT8

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT9

**LABEL:** Claim Procedure Code IX Date

**DESCRIPTION:** The date on which the 9<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT9

**LONG NAME:** PRCDR\_DT9

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT10

**LABEL:** Claim Procedure Code X Date

**DESCRIPTION:** The date on which the 10<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT10

**LONG NAME:** PRCDR\_DT10

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT11

**LABEL:** Claim Procedure Code XI Date

**DESCRIPTION:** The date on which the 11<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT11

**LONG NAME:** PRCDR\_DT11

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT12

**LABEL:** Claim Procedure Code XII Date

**DESCRIPTION:** The date on which the 12<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT12

**LONG NAME:** PRCDR\_DT12

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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### PRCDR\_DT13

**LABEL:** Claim Procedure Code XIII Date

**DESCRIPTION:** The date on which the 13<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT13

**LONG NAME:** PRCDR\_DT13

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT14

**LABEL:** Claim Procedure Code XIV Date

**DESCRIPTION:** The date on which the 14<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT14

**LONG NAME:** PRCDR\_DT14

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT15

**LABEL:** Claim Procedure Code XV Date

**DESCRIPTION:** The date on which the 15<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT15

**LONG NAME:** PRCDR\_DT15

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT16

**LABEL:** Claim Procedure Code XVI Date

**DESCRIPTION:** The date on which the 16<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT16

**LONG NAME:** PRCDR\_DT16

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT17

**LABEL:** Claim Procedure Code XVII Date

**DESCRIPTION:** The date on which the 17<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT17

**LONG NAME:** PRCDR\_DT17

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT18

**LABEL:** Claim Procedure Code XVIII Date

**DESCRIPTION:** The date on which the 18<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT18

**LONG NAME:** PRCDR\_DT18

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT19

**LABEL:** Claim Procedure Code XIX Date

**DESCRIPTION:** The date on which the 19<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT19

**LONG NAME:** PRCDR\_DT19

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT20

**LABEL:** Claim Procedure Code XX Date

**DESCRIPTION:** The date on which the 20<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT20

**LONG NAME:** PRCDR\_DT20

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT21

**LABEL:** Claim Procedure Code XXI Date

**DESCRIPTION:** The date on which the 21<sup>st</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT21

**LONG NAME:** PRCDR\_DT21

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT22

**LABEL:** Claim Procedure Code XXII Date

**DESCRIPTION:** The date on which the 22<sup>nd</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT22

**LONG NAME:** PRCDR\_DT22

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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### PRCDR\_DT23

**LABEL:** Claim Procedure Code XXIII Date

**DESCRIPTION:** The date on which the 23<sup>rd</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT23

**LONG NAME:** PRCDR\_DT23

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT24

**LABEL:** Claim Procedure Code XXIV Date

**DESCRIPTION:** The date on which the 24<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT24

**LONG NAME:** PRCDR\_DT24

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRCDR\_DT25

**LABEL:** Claim Procedure Code XXV Date

**DESCRIPTION:** The date on which the 25<sup>th</sup> procedure was performed.

**SHORT NAME:** PRCDR\_DT25

**LONG NAME:** PRCDR\_DT25

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRF\_PHYSN\_NPI

**LABEL:** Carrier Line Performing NPI Number

**DESCRIPTION:** The National Provider Identifier (NPI) assigned to the performing provider.

**SHORT NAME:** PRFNPI

**LONG NAME:** PRF\_PHYSN\_NPI

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Effective May 2007, the NPI became the national standard identifier for covered health care providers. NPIs replaced the legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

The UPIN is almost never populated after 2009.

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## PRF\_PHYSN\_UPIN

**LABEL:** Carrier Line Performing UPIN Number

**DESCRIPTION:** The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC).

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** PRF\_UPIN

**LONG NAME:** PRF\_PHYSN\_UPIN

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRNCPAL\_DGNS\_CD

**LABEL:** Claim Principal Diagnosis Code

**DESCRIPTION:** The 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.

This data is also redundantly stored as the first occurrence of the diagnosis code (variable called ICD\_DGNS\_CD1).

**SHORT NAME:** PRNCPAL\_DGNS\_CD

**LONG NAME:** PRNCPAL\_DGNS\_CD

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## PRNCPAL\_DGNS\_VRSN\_CD

**LABEL:** Claim Principal Diagnosis Version Code

**DESCRIPTION:** Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9/ICD-10.

**SHORT NAME:** PRNCPAL\_DGNS\_VRSN\_CD

**LONG NAME:** PRNCPAL\_DGNS\_VRSN\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9  
9 = ICD-9  
0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## PRTCPTNG\_IND\_CD

**LABEL:** Line Provider Participating Indicator Code

**DESCRIPTION:** Code indicating whether or not a provider is participating (accepting assignment) for this line item service on the non-institutional claim.

**SHORT NAME:** PRTCPTG

**LONG NAME:** PRTCPTNG\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|     |                                                                                                           |
|-----|-----------------------------------------------------------------------------------------------------------|
| 1 = | Participating                                                                                             |
| 2 = | All or some covered and allowed expenses applied to deductible Participating                              |
| 3 = | Assignment accepted/non-participating                                                                     |
| 4 = | Assignment not accepted/non-participating                                                                 |
| 5 = | Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating. |
| 6 = | Assignment not accepted and all covered and allowed expenses applied to deductible non- participating.    |
| 7 = | Participating provider not accepting assignment                                                           |

**COMMENT:** -

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## PRVDR\_NPI

**LABEL:** DMERC Line Item Supplier NPI Number

**DESCRIPTION:** The National Provider Identifier (NPI) assigned to the supplier of the Part B service/DMEPOS line item.

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** SUP\_NPI

**LONG NAME:** PRVDR\_NPI

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PRVDR\_NUM

**LABEL:** Provider Number

**DESCRIPTION:** This variable is the provider identification number.

The first two digits indicate the state where the provider is located, using the SSA state codes; the middle two characters indicate the type of provider; and the last two digits are used as a counter for the number of providers within that state and type of provider (i.e., this is a unique but not necessarily sequential number).

**SHORT NAME:** PROVIDER

**LONG NAME:** PRVDR\_NUM

**TYPE:** CHAR

**LENGTH:** 6

**SOURCE:** -

**VALUES:** The following blocks of numbers are reserved for the facilities indicated

(NOTE: may have different meanings dependent on the Type of Bill [TOB]):

|           |                                                                                                                        |
|-----------|------------------------------------------------------------------------------------------------------------------------|
| 0001-0879 | Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X                              |
| 0880-0899 | Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X        |
| 0900-0999 | Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X        |
| 1000-1199 | Reserved for future use                                                                                                |
| 1200-1224 | Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X                |
| 1225-1299 | Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X                                           |
| 1300-1399 | Critical Access Hospitals (CAH)                                                                                        |
| 1400-1499 | Continuation of 4900-4999 series (CMHC)                                                                                |
| 1500-1799 | Hospices                                                                                                               |
| 1800-1989 | Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X |
| 1990-1999 | Religious Nonmedical Health Care Institutions (RNHCI)                                                                  |
| 2000-2299 | Long-term hospitals                                                                                                    |

|           |                                                                                                   |
|-----------|---------------------------------------------------------------------------------------------------|
| 2300-2499 | Chronic renal disease facilities (hospital based)                                                 |
| 2500-2899 | Non-hospital renal disease treatment centers                                                      |
| 2900-2999 | Independent special purpose renal dialysis facility (1)                                           |
| 3000-3024 | Formerly tuberculosis hospitals (numbers retired)                                                 |
| 3025-3099 | Rehabilitation hospitals                                                                          |
| 3100-3199 | Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) |
| 3200-3299 | Continuation of 4800-4899 series (CORF)                                                           |
| 3300-3399 | Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X             |
| 3400-3499 | Continuation of rural health clinics (provider-based) (3975-3999)                                 |
| 3500-3699 | Renal disease treatment centers (hospital satellites)                                             |
| 3700-3799 | Hospital based special purpose renal dialysis facility (1)                                        |
| 3800-3974 | Rural health clinics (free-standing)                                                              |
| 3975-3999 | Rural health clinics (provider-based)                                                             |
| 4000-4499 | Psychiatric hospitals                                                                             |
| 4500-4599 | Comprehensive Outpatient Rehabilitation Facilities (CORF)                                         |
| 4600-4799 | Community Mental Health Centers (CMHC)                                                            |
| 4800-4899 | Continuation of 4500-4599 series (CORF)                                                           |
| 4900-4999 | Continuation of 4600-4799 series (CMHC)                                                           |
| 5000-6499 | Skilled Nursing Facilities                                                                        |
| 6500-6989 | CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X                 |
| 6990-6999 | Numbers Reserved (formerly Christian Science)                                                     |
| 7000-7299 | Home Health Agencies (HHA) (2)                                                                    |
| 7300-7399 | Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)                                |
| 7400-7799 | Continuation of 7000-7299 series                                                                  |
| 7800-7999 | Subunits of state and local governmental Home Health Agencies (3)                                 |
| 8000-8499 | Continuation of 7400-7799 series (HHA)                                                            |
| 8500-8899 | Continuation of rural health center (provider based) (3400-3499)                                  |

|           |                                                                 |
|-----------|-----------------------------------------------------------------|
| 8900-8999 | Continuation of rural health center (free-standing) (3800-3974) |
| 9000-9799 | Continuation of 8000-8499 series (HHA)                          |
| 9800-9899 | Transplant Centers (eff. 10/1/07)                               |
| 9900-9999 | Reserved for future use                                         |

**NOTE:** There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

M = Psychiatric Unit in Critical Access Hospital

R = Rehabilitation Unit in Critical Access Hospital

S = Psychiatric unit (excluded from PPS)

T = Rehabilitation unit (excluded from PPS)

U = Swing-Bed Hospital Designation for Short-Term Hospitals

V = Alcohol drug unit (prior to 10/87 only)

W = Swing-Bed Hospital Designation for Long Term Care Hospitals

Y = Swing-Bed Hospital Designation for Rehabilitation Hospitals

Z = Swing Bed Designation for Critical Access Hospitals

There is also a special numbering system for assigning emergency hospital identification numbers (non-participating hospitals).

The sixth position of the provider number is as follows:

E = Non-federal emergency hospital

F = Federal emergency hospital

**COMMENT:** Refer to CCW Technical Guidance document: "Getting Started with Medicare Data" for additional information regarding service setting classifications.

If you want additional information about the institutional provider, the quarterly CMS Provider of Services (POS) file contains dozens of variables that describe the characteristics of the provider. This file is updated quarterly, and effective May 2014 is available for free online from the CMS website (2005-current).



## PRPAYAMT

**LABEL:** NCH Primary Payer (if not Medicare) Claim Paid Amount

**DESCRIPTION:** The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.

**SHORT NAME:** PRPAYAMT

**LONG NAME:** NCH\_PRMRY\_PYR\_CLM\_PD\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Derivation Rules: It is calculated as the sum of the line-level primary payer amounts.

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## PRVDR\_SPCLTY

**LABEL:** Line CMS Provider Specialty Code

**DESCRIPTION:** CMS (previously called HCFA) specialty code used for pricing the line item service on the non-institutional claim.

Assigned by the Medicare Administrative Contractor (MAC) based on the corresponding provider identification number (performing NPI or UPIN).

**SHORT NAME:** HCFASPC

**LONG NAME:** PRVDR\_SPCLTY

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:**

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/03)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech / language pathology
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = General Psychiatry
- 28 = Colorectal surgery (formerly proctology)

- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation
- 32 = Anesthesiologist Assistants (eff. 4/1/03--previously grouped with Certified Registered Nurse Anesthetists [CRNA])
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometrist
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/03)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
- 47 = Independent Diagnostic Testing Facility (IDTF)
- 48 = Podiatry
- 49 = Ambulatory surgical center (formerly miscellaneous)
- 50 = Nurse practitioner
- 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
- 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 54 = Medical supply company for DMERC (and not included in 51-53)
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-orthotist
- 58 = Medical supply company with registered pharmacist
- 59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
- 60 = Public health or welfare agencies (federal, state, and local)
- 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
- 62 = Psychologist (billing independently)
- 63 = Portable X-ray supplier
- 64 = Audiologist (billing independently)

- 65 = Physical therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 66 = Rheumatology
- 67 = Occupational therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 68 = Clinical psychologist
- 69 = Clinical laboratory (billing independently)
- 70 = Multispecialty clinic or group practice
- 71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
- 72 = Pain Management (eff. 1/1/02)
- 73 = Mass Immunization Roster Biller
- 74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF))
- 75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs -- eff. 4/1/03)
- 76 = Peripheral vascular disease
- 77 = Vascular surgery
- 78 = Cardiac surgery
- 79 = Addiction medicine
- 80 = Licensed clinical social worker
- 81 = Critical care (intensivists)
- 82 = Hematology
- 83 = Hematology/oncology
- 84 = Preventive medicine
- 85 = Maxillofacial surgery
- 86 = Neuropsychiatry
- 87 = All other suppliers (e.g. drug and department stores)
- 88 = Unknown supplier/provider specialty
- 89 = Certified clinical nurse specialist
- 90 = Medical oncology
- 91 = Surgical oncology
- 92 = Radiation oncology
- 93 = Emergency medicine
- 94 = Interventional radiology
- 95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory
- 96 = Optician
- 97 = Physician assistant
- 98 = Gynecologist/oncologist
- 99 = Unknown physician specialty
- A0 = Hospital (DMERCs only)
- A1 = SNF (DMERCs only)
- A2 = Intermediate care nursing facility (DMERCs only)
- A3 = Nursing facility, other (DMERCs only)

- A4 = Home Health Agency (DMERCs only)
- A5 = Pharmacy (DMERC)
- A6 = Medical supply company with respiratory therapist (DMERCs only)
- A7 = Department store (DMERC)
- A8 = Grocery store (DMERC)
- A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities, eff. 1/2005)
- B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)
- B2 = Pedorthic Personnel (eff. 10/2/07)
- B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/07)
- B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/07)
- B5 = Ocularist
- C0 = Sleep medicine
- C1 = Centralized flu
- C2 = Indirect payment procedure
- C3 = Interventional cardiology

**COMMENT:** -

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## PRVDR\_STATE\_CD

**LABEL:** NCH Provider SSA State Code

**DESCRIPTION:** The two -digit numeric social security administration (SSA) state code where provider or facility is located.

**SHORT NAME:** PRSTATE

**LONG NAME:** PRVDR\_STATE\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

|      |                      |
|------|----------------------|
| 00 = | Unknown/other        |
| 01 = | Alabama              |
| 02 = | Alaska               |
| 03 = | Arizona              |
| 04 = | Arkansas             |
| 05 = | California           |
| 06 = | Colorado             |
| 07 = | Connecticut          |
| 08 = | Delaware             |
| 09 = | District of Columbia |
| 10 = | Florida              |
| 11 = | Georgia              |
| 12 = | Hawaii               |
| 13 = | Idaho                |
| 14 = | Illinois             |
| 15 = | Indiana              |
| 16 = | Iowa                 |
| 17 = | Kansas               |
| 18 = | Kentucky             |
| 19 = | Louisiana            |
| 20 = | Maine                |
| 21 = | Maryland             |
| 22 = | Massachusetts        |
| 23 = | Michigan             |
| 24 = | Minnesota            |
| 25 = | Mississippi          |
| 26 = | Missouri             |
| 27 = | Montana              |
| 28 = | Nebraska             |
| 29 = | Nevada               |
| 30 = | New Hampshire        |

31 = New Jersey  
 32 = New Mexico  
 33 = New York  
 34 = North Carolina  
 35 = North Dakota  
 36 = Ohio  
 37 = Oklahoma  
 38 = Oregon  
 39 = Pennsylvania  
 40 = Puerto Rico  
 41 = Rhode Island  
 42 = South Carolina  
 43 = South Dakota  
 44 = Tennessee  
 45 = Texas  
 46 = Utah  
 47 = Vermont  
 48 = Virgin Islands  
 49 = Virginia  
 50 = Washington  
 51 = West Virginia  
 52 = Wisconsin  
 53 = Wyoming  
 54 = Africa  
 55 = California  
 56 = Canada & Islands  
 57 = Central America and West Indies  
 58 = Europe  
 59 = Mexico  
 60 = Oceania  
 61 = Philippines  
 62 = South America  
 63 = U.S. Possessions  
 64 = American Samoa  
 65 = Guam  
 66 = Commonwealth of the Northern Marianas Islands  
 67 = Texas  
 68 = Florida (eff. 10/2005)  
 69 = Florida (eff. 10/2005)  
 70 = Kansas (eff. 10/2005)  
 71 = Louisiana (eff. 10/2005)  
 72 = Ohio (eff. 10/2005)  
 73 = Pennsylvania (eff. 10/2005)  
 74 = Texas (eff. 10/2005)

80 = Maryland (eff. 8/2000)  
97 = Northern Marianas  
98 = Guam  
99 = With 000 county code is American Samoa;  
otherwise unknown

**COMMENT:** When this variable appears in the Carrier file, it has a different short SAS name (PRVSTATE).

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## PRVDR\_ZIP

**LABEL:** Carrier Line Performing Provider ZIP Code

**DESCRIPTION:** The ZIP code of the physician/supplier who performed the Part B service for this line item on the carrier claim (non-DMERC).

**SHORT NAME:** PROVZIP

**LONG NAME:** PRVDR\_ZIP

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## PTNT\_DSCHRG\_STUS\_CD

**LABEL:** Patient Discharge Status Code

**DESCRIPTION:** The code used to identify the status of the patient as of the CLM\_THRU\_DT.

**SHORT NAME:** STUS\_CD

**LONG NAME:** PTNT\_DSCHRG\_STUS\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 0 = Unknown Value (but present in data)
- 01 = Discharged to home/self-care (routine charge).
- 02 = Discharged/transferred to other short term general hospital for inpatient care.
- 03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care -- (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
- 04 = Discharged/transferred to intermediate care facility (ICF).
- 05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.
- 06 = Discharged/transferred to home care of organized home health service organization.
- 07 = Left against medical advice or discontinued care.
- 08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)
- 09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
- 20 = Expired (patient did not recover).
- 21 = Discharged/transferred to court/law enforcement.

- 30 = Still patient.
- 40 = Expired at home (hospice claims only)
- 41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
- 42 = Expired - place unknown (Hospice claims only)
- 43 = Discharged/transferred to a federal hospital (eff. 10/1/03)
- 50 = Discharged/transferred to a Hospice – home.
- 51 = Discharged/transferred to a Hospice – medical facility.
- 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
- 62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
- 63 = Discharged/transferred to a long term care hospitals. (eff. 1/2002)
- 64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002)
- 65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).
- 66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
- 69 = Discharged/transferred to a designated disaster alternative care site (starting 10/2013; applies only to particular MS-DRGs\*)
- 70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.
- 71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
- 72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)

The following codes apply only to particular MS-DRGs\*, and were new in 10/2013:

- 81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission.
- 82 = Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission.
- 83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission.
- 84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.
- 85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission.
- 86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.
- 87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.
- 88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission.
- 89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.
- 90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.
- 91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.
- 92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.
- 93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.
- 94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.
- 95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

**COMMENT:** \* MS-DRG codes where additional codes were available in October 2013 are:  
280 (Acute Myocardial Infarction, Discharged Alive with MCC),  
281 (Acute Myocardial Infarction, Discharged Alive with CC),  
282 (Acute Myocardial Infarction, Discharged Alive without CC/MCC), and  
789 (Neonates, Died or Transferred to Another Acute Care Facility).

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## RC\_PTNT\_ADD\_ON\_PYMT\_AMT

**LABEL:** Revenue Center Patient/Initial Visit Add-On Payment Amount (for initial wellness visit)

**DESCRIPTION:** This field is the revenue-center Patient Initial Visit Add-On Amount. This field represents a base rate increase factor of 1.3516 for new patient initial preventive physical examination (IPPE) and annual wellness visit.

**SHORT NAME:** RC\_PTNT\_ADD\_ON\_PYMT\_AMT

**LONG NAME:** RC\_PTNT\_ADD\_ON\_PYMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is new in October 2014.This field only applies to Outpatient claims.

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## REV\_CNTR

**LABEL:** Revenue Center Code

**DESCRIPTION:** 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.

**SHORT NAME:** REV\_CNTR

**LONG NAME:** REV\_CNTR

**TYPE:** CHAR

**LENGTH:** 4

**SOURCE:** NCH

**VALUES:** 0001 = Total charge

0022 = SNF claim paid under PPS submitted as type of bill (TOB) 21X.

NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.

0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).

0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/01). This code may appear only once on a claim.

0100 = All-inclusive rate - room and board plus ancillary

0101 = All-inclusive rate - room and board

0110 = Private medical or general-general classification

0111 = Private medical or general-medical/surgical/GYN

0112 = Private medical or general-OB

0113 = Private medical or general-pediatric

0114 = Private medical or general-psychiatric

0115 = Private medical or general-hospice

0116 = Private medical or general-detoxification

0117 = Private medical or general-oncology

0118 = Private medical or general-rehabilitation

0119 = Private medical or general-other

0120 = Semi-private 2 bed (medical or general) general classification  
 0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN  
 0122 = Semi-private 2 bed (medical or general)-OB  
 0123 = Semi-private 2 bed (medical or general)-pediatric  
 0124 = Semi-private 2 bed (medical or general)-psychiatric  
 0125 = Semi-private 2 bed (medical or general)-hospice  
 0126 = Semi-private 2 bed (medical or general)-detoxification  
 0127 = Semi-private 2 bed (medical or general)-oncology  
 0128 = Semi-private 2 bed (medical or general)-rehabilitation  
 0129 = Semi-private 2 bed (medical or general)-other  
 0130 = Semi-private 3 and 4 beds-general classification  
 0131 = Semi-private 3 and 4 beds-medical/surgical/GYN  
 0132 = Semi-private 3 and 4 beds-OB  
 0133 = Semi-private 3 and 4 beds-pediatric  
 0134 = Semi-private 3 and 4 beds-psychiatric  
 0135 = Semi-private 3 and 4 beds-hospice  
 0136 = Semi-private 3 and 4 beds-detoxification  
 0137 = Semi-private 3 and 4 beds-oncology  
 0138 = Semi-private 3 and 4 beds-rehabilitation  
 0139 = Semi-private 3 and 4 beds-other  
 0140 = Private (deluxe)-general classification  
 0141 = Private (deluxe)-medical/surgical/GYN  
 0142 = Private (deluxe)-OB  
 0143 = Private (deluxe)-pediatric  
 0144 = Private (deluxe)-psychiatric  
 0145 = Private (deluxe)-hospice  
 0146 = Private (deluxe)-detoxification  
 0147 = Private (deluxe)-oncology  
 0148 = Private (deluxe)-rehabilitation  
 0149 = Private (deluxe)-other  
 0150 = Room & Board ward (medical or general)-general classification  
 0151 = Room & Board ward (medical or general)-medical/surgical/GYN  
 0152 = Room & Board ward (medical or general)-OB  
 0153 = Room & Board ward (medical or general)-pediatric  
 0154 = Room & Board ward (medical or general)-psychiatric  
 0155 = Room & Board ward (medical or general)-hospice  
 0156 = Room & Board ward (medical or general)-detoxification  
 0157 = Room & Board ward (medical or general)-oncology  
 0158 = Room & Board ward (medical or general)-rehabilitation  
 0159 = Room & Board ward (medical or general)-other  
 0160 = Other Room & Board-general classification  
 0164 = Other Room & Board-sterile environment  
 0167 = Other Room & Board-self care  
 0169 = Other Room & Board-other

0170 = Nursery-general classification  
 0171 = Nursery-newborn level I (routine)  
 0172 = Nursery-premature newborn-level II (continuing care)  
 0173 = Nursery-newborn-level III (intermediate care)  
 0174 = Nursery-newborn-level IV (intensive care)  
 0179 = Nursery-other  
 0180 = Leave of absence-general classification  
 0182 = Leave of absence-patient convenience charges billable  
 0183 = Leave of absence-therapeutic leave  
 0184 = Leave of absence-ICF mentally retarded-any reason  
 0185 = Leave of absence-nursing home (hospitalization)  
 0189 = Leave of absence-other leave of absence  
 0190 = Subacute care - general classification  
 0191 = Subacute care - level I  
 0192 = Subacute care - level II  
 0193 = Subacute care - level III  
 0194 = Subacute care - level IV  
 0199 = Subacute care - other  
 0200 = Intensive care-general classification  
 0201 = Intensive care-surgical  
 0202 = Intensive care-medical  
 0203 = Intensive care-pediatric  
 0204 = Intensive care-psychiatric  
 0206 = Intensive care-post ICU; redefined as intermediate ICU  
 0207 = Intensive care-burn care  
 0208 = Intensive care-trauma  
 0209 = Intensive care-other intensive care  
 0210 = Coronary care-general classification  
 0211 = Coronary care-myocardial infraction  
 0212 = Coronary care-pulmonary care  
 0213 = Coronary care-heart transplant  
 0214 = Coronary care-post CCU; redefined as intermediate CCU  
 0219 = Coronary care-other coronary care  
 0220 = Special charges-general classification  
 0221 = Special charges-admission charge  
 0222 = Special charges-technical support charge  
 0223 = Special charges-UR service charge  
 0224 = Special charges-late discharge, medically necessary  
 0229 = Special charges-other special charges  
 0230 = Incremental nursing charge rate-general classification  
 0231 = Incremental nursing charge rate-nursery  
 0232 = Incremental nursing charge rate-OB  
 0233 = Incremental nursing charge rate-ICU (include transitional care)  
 0234 = Incremental nursing charge rate-CCU (include transitional care)



0235 = Incremental nursing charge rate-hospice  
 0239 = Incremental nursing charge rate-other  
 0240 = All-inclusive ancillary-general classification  
 0241 = All-inclusive ancillary-basic  
 0242 = All-inclusive ancillary-comprehensive  
 0243 = All-inclusive ancillary-specialty  
 0249 = All-inclusive ancillary-other inclusive ancillary  
 0250 = Pharmacy-general classification  
 0251 = Pharmacy-generic drugs  
 0252 = Pharmacy-nongeneric drugs  
 0253 = Pharmacy-take home drugs  
 0254 = Pharmacy-drugs incident to other diagnostic service-subject  
         to payment limit  
 0255 = Pharmacy-drugs incident to radiology-subject to payment limit  
 0256 = Pharmacy-experimental drugs  
 0257 = Pharmacy-non-prescription  
 0258 = Pharmacy-IV solutions  
 0259 = Pharmacy-other pharmacy  
 0260 = IV therapy-general classification  
 0261 = IV therapy-infusion pump  
 0262 = IV therapy-pharmacy services  
 0263 = IV therapy-drug supply/delivery  
 0264 = IV therapy-supplies  
 0269 = IV therapy-other IV therapy  
 0270 = Medical/surgical supplies-general classification (also see 062X)  
 0271 = Medical/surgical supplies-nonsterile supply  
 0272 = Medical/surgical supplies-sterile supply  
 0273 = Medical/surgical supplies-take home supplies  
 0274 = Medical/surgical supplies-prosthetic/orthotic devices  
 0275 = Medical/surgical supplies-pace maker  
 0276 = Medical/surgical supplies-intraocular lens  
 0277 = Medical/surgical supplies-oxygen-take home  
 0278 = Medical/surgical supplies-other implants  
 0279 = Medical/surgical supplies-other devices  
 0280 = Oncology-general classification  
 0289 = Oncology-other oncology  
 0290 = DME (other than renal)-general classification  
 0291 = DME (other than renal)-rental  
 0292 = DME (other than renal)-purchase of new DME  
 0293 = DME (other than renal)-purchase of used DME  
 0294 = DME (other than renal)-related to and listed as DME  
 0299 = DME (other than renal)-other  
 0300 = Laboratory-general classification  
 0301 = Laboratory-chemistry

0302 = Laboratory-immunology  
 0303 = Laboratory-renal patient (home)  
 0304 = Laboratory-non-routine dialysis  
 0305 = Laboratory-hematology  
 0306 = Laboratory-bacteriology & microbiology  
 0307 = Laboratory-urology  
 0309 = Laboratory-other laboratory  
 0310 = Laboratory pathological-general classification  
 0311 = Laboratory pathological-cytology  
 0312 = Laboratory pathological-histology  
 0314 = Laboratory pathological-biopsy  
 0319 = Laboratory pathological-other  
 0320 = Radiology diagnostic-general classification  
 0321 = Radiology diagnostic-angiocardiology  
 0322 = Radiology diagnostic-arthrography  
 0323 = Radiology diagnostic-arteriography  
 0324 = Radiology diagnostic-chest X-ray  
 0329 = Radiology diagnostic-other  
 0330 = Radiology therapeutic-general classification  
 0331 = Radiology therapeutic-chemotherapy injected  
 0332 = Radiology therapeutic-chemotherapy oral  
 0333 = Radiology therapeutic-radiation therapy  
 0335 = Radiology therapeutic-chemotherapy IV  
 0339 = Radiology therapeutic-other  
 0340 = Nuclear medicine-general classification  
 0341 = Nuclear medicine-diagnostic  
 0342 = Nuclear medicine-therapeutic  
 0349 = Nuclear medicine-other  
 0350 = Computed tomographic (CT) scan-general classification  
 0351 = CT scan-head scan  
 0352 = CT scan-body scan  
 0359 = CT scan-other CT scans  
 0360 = Operating room services-general classification  
 0361 = Operating room services-minor surgery  
 0362 = Operating room services-organ transplant, other than kidney  
 0367 = Operating room services-kidney transplant  
 0369 = Operating room services-other operating room services  
 0370 = Anesthesia-general classification  
 0371 = Anesthesia-incident to RAD and subject to the payment limit  
 0372 = Anesthesia-incident to other diagnostic service and subject  
         to the payment limit  
 0374 = Anesthesia-acupuncture  
 0379 = Anesthesia-other anesthesia  
 0380 = Blood-general classification

0381 = Blood-packed red cells  
0382 = Blood-whole blood  
0383 = Blood-plasma  
0384 = Blood-platelets  
0385 = Blood-leukocytes  
0386 = Blood-other components  
0387 = Blood-other derivatives (cryoprecipitates)  
0389 = Blood-other blood  
0390 = Blood storage and processing-general classification  
0391 = Blood storage and processing-blood administration  
0399 = Blood storage and processing-other  
0400 = Other imaging services-general classification  
0401 = Other imaging services-diagnostic mammography  
0402 = Other imaging services-ultrasound  
0403 = Other imaging services-screening mammography  
0404 = Other imaging services-positron emission tomography  
0409 = Other imaging services-other  
0410 = Respiratory services-general classification  
0412 = Respiratory services-inhalation services  
0413 = Respiratory services-hyperbaric oxygen therapy  
0419 = Respiratory services-other  
0420 = Physical therapy-general classification  
0421 = Physical therapy-visit charge  
0422 = Physical therapy-hourly charge  
0423 = Physical therapy-group rate  
0424 = Physical therapy-evaluation or re-evaluation  
0429 = Physical therapy-other  
0430 = Occupational therapy-general classification  
0431 = Occupational therapy-visit charge  
0432 = Occupational therapy-hourly charge  
0433 = Occupational therapy-group rate  
0434 = Occupational therapy-evaluation or re-evaluation  
0439 = Occupational therapy-other (may include restorative therapy)  
0440 = Speech language pathology-general classification  
0441 = Speech language pathology-visit charge  
0442 = Speech language pathology-hourly charge  
0443 = Speech language pathology-group rate  
0444 = Speech language pathology-evaluation or re-evaluation  
0449 = Speech language pathology-other  
0450 = Emergency room - general classification  
0451 = Emergency room - EMTALA emergency medical screening services  
0452 = Emergency room - ER beyond EMTALA screening  
0456 = Emergency room-urgent care  
0459 = Emergency room-other

0460 = Pulmonary function-general classification  
 0469 = Pulmonary function-other  
 0470 = Audiology-general classification  
 0471 = Audiology-diagnostic  
 0472 = Audiology-treatment  
 0479 = Audiology-other  
 0480 = Cardiology-general classification  
 0481 = Cardiology-cardiac cath lab  
 0482 = Cardiology-stress test  
 0483 = Cardiology-Echocardiology  
 0489 = Cardiology-other  
 0490 = Ambulatory surgical care-general classification  
 0499 = Ambulatory surgical care-other  
 0500 = Outpatient services-general classification  
 0509 = Outpatient services-other  
 0510 = Clinic-general classification  
 0511 = Clinic-chronic pain center  
 0512 = Clinic-dental center  
 0513 = Clinic-psychiatric  
 0514 = Clinic-OB-GYN  
 0515 = Clinic-pediatric  
 0516 = Clinic-urgent care clinic  
 0517 = Clinic-family practice clinic  
 0519 = Clinic-other  
 0520 = Free-standing clinic-general classification  
 0521 = Free-standing clinic-Clinic visit by a member to RHC/FQHC  
     (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Clinic  
 0522 = Free-standing clinic-Home visit by RHC/FQHC practitioner  
     (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Home  
 0523 = Free-standing clinic-family practice  
 0524 = Free-standing clinic - visit by RHC/FQHC practitioner to a  
     member in a covered Part A stay at the SNF. (eff. 7/1/06)  
 0525 = Free-standing clinic - visit by RHC/FQHC practitioner to a  
     member in a SNF (not in a covered Part A stay) or NF or ICF  
     MR or other residential facility. (eff. 7/1/06)  
 0526 = Free-standing clinic-urgent care (eff 10/96)  
 0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a  
     member's home when in a home health shortage area. (eff. 7/1/06)  
 0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other  
     non-RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)  
 0529 = Free-standing clinic-other  
 0530 = Osteopathic services-general classification  
 0531 = Osteopathic services-osteopathic therapy  
 0539 = Osteopathic services-other

0540 = Ambulance-general classification  
 0541 = Ambulance-supplies  
 0542 = Ambulance-medical transport  
 0543 = Ambulance-heart mobile  
 0544 = Ambulance-oxygen  
 0545 = Ambulance-air ambulance  
 0546 = Ambulance-neo-natal ambulance  
 0547 = Ambulance-pharmacy  
 0548 = Ambulance-telephone transmission EKG  
 0549 = Ambulance-other  
 0550 = Skilled nursing-general classification  
 0551 = Skilled nursing-visit charge  
 0552 = Skilled nursing-hourly charge  
 0559 = Skilled nursing-other  
 0560 = Medical social services-general classification  
 0561 = Medical social services-visit charge  
 0562 = Medical social services-hourly charges  
 0569 = Medical social services-other  
 0570 = Home health aid (home health)-general classification  
 0571 = Home health aid (home health)-visit charge  
 0572 = Home health aid (home health)-hourly charge  
 0579 = Home health aid (home health)-other  
 0580 = Other visits (home health)-general classification (under HHPPS, not allowed as covered charges)  
 0581 = Other visits (home health)-visit charge (under HHPPS, not allowed as covered charges)  
 0582 = Other visits (home health)-hourly charge (under HHPPS, not allowed as covered charges)  
 0589 = Other visits (home health)-other (under HHPPS, not allowed as covered charges)  
 0590 = Units of service (home health)-general classification (under HHPPS, not allowed as covered charges)  
 0599 = Units of service (home health)-other (under HHPPS, not allowed as covered charges)  
 0600 = Oxygen/Home Health-general classification  
 0601 = Oxygen/Home Health-stat or port equip/supply or count  
 0602 = Oxygen/Home Health-stat/equip/under 1 LPM  
 0603 = Oxygen/Home Health-stat/equip/over 4 LPM  
 0604 = Oxygen/Home Health-stat/equip/portable add-on  
 0610 = Magnetic resonance technology (MRT)-general classification  
 0611 = MRT/MRI-brain (including brainstem)  
 0612 = MRT/MRI-spinal cord (including spine)  
 0614 = MRT/MRI-other  
 0615 = MRT/MRA-Head and Neck

0616 = MRT/MRA-Lower Extremities  
 0618 = MRT/MRA-other  
 0619 = MRT/Other MRI  
 0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit - extension of 027X  
 0622 = Medical/surgical supplies-incident to other diagnostic service-subject to the payment limit - extension of 027X  
 0623 = Medical/surgical supplies-surgical dressings - extension of 027X  
 0624 = Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE's - extension of 027X  
 0630 = Reserved  
 0631 = Drugs requiring specific identification-single drug source  
 0632 = Drugs requiring specific identification-multiple drug source  
 0633 = Drugs requiring specific identification-restrictive prescription  
 0634 = Drugs requiring specific identification-EPO under 10,000 units  
 0635 = Drugs requiring specific identification-EPO 10,000 units or more  
 0636 = Drugs requiring specific identification-detailed coding  
 0637 = Self-administered drugs administered in an emergency situation - not requiring detailed coding  
 0640 = Home IV therapy-general classification  
 0641 = Home IV therapy-nonroutine nursing  
 0642 = Home IV therapy-IV site care, central line  
 0643 = Home IV therapy-IV start/change peripheral line  
 0644 = Home IV therapy-nonroutine nursing, peripheral line  
 0645 = Home IV therapy-train patient/caregiver, central line  
 0646 = Home IV therapy-train disabled patient, central line  
 0647 = Home IV therapy-train patient/caregiver, peripheral line  
 0648 = Home IV therapy-train disabled patient, peripheral line  
 0649 = Home IV therapy-other IV therapy services  
 0650 = Hospice services-general classification  
 0651 = Hospice services-routine home care  
 0652 = Hospice services-continuous home care-1/2  
 0655 = Hospice services-inpatient care  
 0656 = Hospice services-general inpatient care (non-respite)  
 0657 = Hospice services-physician services  
 0659 = Hospice services-other  
 0660 = Respite care (HHA)-general classification  
 0661 = Respite care (HHA)-hourly charge/skilled nursing  
 0662 = Respite care (HHA)-hourly charge/home health aide/homemaker  
 0670 = OP special residence charges - general classification  
 0671 = OP special residence charges - hospital based  
 0672 = OP special residence charges - contracted  
 0679 = OP special residence charges - other special residence charges  
 0700 = Cast room-general classification

0709 = Cast room-other  
 0710 = Recovery room-general classification  
 0719 = Recovery room-other  
 0720 = Labor room/delivery-general classification  
 0721 = Labor room/delivery-labor  
 0722 = Labor room/delivery-delivery  
 0723 = Labor room/delivery-circumcision  
 0724 = Labor room/delivery-birthing center  
 0729 = Labor room/delivery-other  
 0730 = EKG/ECG-general classification  
 0731 = EKG/ECG-Holter monitor  
 0732 = EKG/ECG-telemetry  
 0739 = EKG/ECG-other  
 0740 = EEG-general classification  
 0749 = EEG (electroencephalogram)-other  
 0750 = Gastro-intestinal services-general classification  
 0759 = Gastro-intestinal services-other  
 0760 = Treatment or observation room-general classification  
 0761 = Treatment or observation room-treatment room  
 0762 = Treatment or observation room-observation room  
 0769 = Treatment or observation room-other  
 0770 = Preventative care services-general classification  
 0771 = Preventative care services-vaccine administration  
 0779 = Preventative care services-other  
 0780 = Telemedicine - general classification  
 0789 = Telemedicine - telemedicine  
 0790 = Lithotripsy-general classification  
 0799 = Lithotripsy-other  
 0800 = Inpatient renal dialysis-general classification  
 0801 = Inpatient renal dialysis-inpatient hemodialysis  
 0802 = Inpatient renal dialysis-inpatient peritoneal (non-CAPD)  
 0803 = Inpatient renal dialysis-inpatient CAPD  
 0804 = Inpatient renal dialysis-inpatient CCPD  
 0809 = Inpatient renal dialysis-other inpatient dialysis  
 0810 = Organ acquisition-general classification  
 0811 = Organ acquisition-living donor  
 0812 = Organ acquisition-cadaver donor  
 0813 = Organ acquisition-unknown donor  
 0814 = Organ acquisition - unsuccessful organ search-donor bank charges  
 0815 = Allogeneic Stem Cell Acquisition/Donor Services  
 0819 = Organ acquisition-other donor  
 0820 = Hemodialysis OP or home dialysis-general classification  
 0821 = Hemodialysis OP or home dialysis-hemodialysis-composite or other  
       rate

0822 = Hemodialysis OP or home dialysis-home supplies  
 0823 = Hemodialysis OP or home dialysis-home equipment  
 0824 = Hemodialysis OP or home dialysis-maintenance/100%  
 0825 = Hemodialysis OP or home dialysis-support services  
 0829 = Hemodialysis OP or home dialysis-other  
 0830 = Peritoneal dialysis OP or home-general classification  
 0831 = Peritoneal dialysis OP or home-peritoneal-composite or other rate  
 0832 = Peritoneal dialysis OP or home-home supplies  
 0833 = Peritoneal dialysis OP or home-home equipment  
 0834 = Peritoneal dialysis OP or home-maintenance/100%  
 0835 = Peritoneal dialysis OP or home-support services  
 0839 = Peritoneal dialysis OP or home-other  
 0840 = CAPD outpatient-general classification  
 0841 = CAPD outpatient-CAPD/composite or other rate  
 0842 = CAPD outpatient-home supplies  
 0843 = CAPD outpatient-home equipment  
 0844 = CAPD outpatient-maintenance/100%  
 0845 = CAPD outpatient-support services  
 0849 = CAPD outpatient-other  
 0850 = CCPD outpatient-general classification  
 0851 = CCPD outpatient-CCPD/composite or other rate  
 0852 = CCPD outpatient-home supplies  
 0853 = CCPD outpatient-home equipment  
 0854 = CCPD outpatient-maintenance/100%  
 0855 = CCPD outpatient-support services  
 0859 = CCPD outpatient-other  
 0880 = Miscellaneous dialysis-general classification  
 0881 = Miscellaneous dialysis-ultrafiltration  
 0882 = Miscellaneous dialysis-home dialysis aide visit  
 0889 = Miscellaneous dialysis-other  
 0890 = Other donor bank-general classification; changed to reserved  
       for national assignment  
 0891 = Other donor bank-bone; changed to reserved for national assignment  
 0892 = Other donor bank-organ (other than kidney); changed to reserved for  
       national assignment  
 0893 = Other donor bank-skin; changed to reserved for national assignment  
 0899 = Other donor bank-other; changed to reserved for national assignment  
 0900 = Behavior Health Treatment/Services - general classification  
       (eff. 10/2004); prior to 10/2004 defined as Psychiatric/  
       psychological treatments-general classification  
 0901 = Behavior Health Treatment/Services - electroshock treatment  
       (eff. 10/2004); prior to 10/2004 defined as Psychiatric/  
       psychological treatments-electroshock treatment



- 0902 = Behavior Health Treatment/Services - milieu therapy (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/psychological treatments-  
milieu therapy
- 0903 = Behavior Health Treatment/Services - play therapy (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/psychological treatments-  
play therapy
- 0904 = Behavior Health Treatment/Services - activity therapy (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/psychological treatments-  
activity therapy
- 0905 = Behavior Health Treatment/Services - intensive outpatient services-  
psychiatric (eff. 10/2004)
- 0906 = Behavior Health Treatment/Services - intensive outpatient services-  
chemical dependency (eff. 10/2004)
- 0907 = Behavior Health Treatment/Services - community behavioral health  
program-day treatment (eff. 10/2004)
- 0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined  
as Psychiatric/psychological treatments-other
- 0910 = Behavioral Health Treatment/Services-Reserved for National Assignment  
(eff. 10/2004); prior to 10/2004 defined as Psychiatric/  
psychological services-general classification
- 0911 = Behavioral Health Treatment/Services-rehabilitation (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/psychological services-  
rehabilitation
- 0912 = Behavioral Health Treatment/Services-partial hospitalization-less  
intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/  
psychological services-less intensive
- 0913 = Behavioral Health Treatment/Services-partial hospitalization-  
intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/  
psychological services-intensive
- 0914 = Behavioral Health Treatment/Services-individual therapy (eff. 10/2004)  
prior to 10/2004 defined as Psychiatric/psychological services-  
individual therapy
- 0915 = Behavioral Health Treatment/Services-group therapy (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/psychological services-  
group therapy
- 0916 = Behavioral Health Treatment/Services-family therapy (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/psychological services-  
family therapy
- 0917 = Behavioral Health Treatment/Services-biofeedback (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/psychological services-  
biofeedback
- 0918 = Behavioral Health Treatment/Services-testing (eff. 10/2004); prior  
to 10/2004 defined as Psychiatric/psychological services-testing
- 0919 = Behavioral Health Treatment/Services-other (eff. 10/2004); prior

to 10/2004 defined as Psychiatric/psychological services-other

0920 = Other diagnostic services-general classification

0921 = Other diagnostic services-peripheral vascular lab

0922 = Other diagnostic services-electromyogram

0923 = Other diagnostic services-pap smear

0924 = Other diagnostic services-allergy test

0925 = Other diagnostic services-pregnancy test

0929 = Other diagnostic services-other

0931 = Medical Rehabilitation Day Program - Half Day

0932 = Medical Rehabilitation Day Program - Full Day

0940 = Other therapeutic services-general classification

0941 = Other therapeutic services-recreational therapy

0942 = Other therapeutic services-education/training (include diabetes diet training)

0943 = Other therapeutic services-cardiac rehabilitation

0944 = Other therapeutic services-drug rehabilitation

0945 = Other therapeutic services-alcohol rehabilitation

0946 = Other therapeutic services-routine complex medical equipment

0947 = Other therapeutic services-ancillary complex medical equipment

0949 = Other therapeutic services-other

0951 = Professional Fees-athletic training (extension of 094X)

0952 = Professional Fees-kinesiotherapy (extension of 094X)

0960 = Professional fees-general classification

0961 = Professional fees-psychiatric

0962 = Professional fees-ophthalmology

0963 = Professional fees-anesthesiologist (MD)

0964 = Professional fees-anesthetist (CRNA)

0969 = Professional fees-other (NOTE: 097X is an extension of 096X)

0971 = Professional fees-laboratory

0972 = Professional fees-radiology diagnostic

0973 = Professional fees-radiology therapeutic

0974 = Professional fees-nuclear medicine

0975 = Professional fees-operating room

0976 = Professional fees-respiratory therapy

0977 = Professional fees-physical therapy

0978 = Professional fees-occupational therapy

0979 = Professional fees-speech pathology (NOTE: 098X is an extension of 096X & 097X)

0981 = Professional fees-emergency room

0982 = Professional fees-outpatient services

0983 = Professional fees-clinic

0984 = Professional fees-medical social services

0985 = Professional fees-EKG

0986 = Professional fees-EEG

0987 = Professional fees-hospital visit  
 0988 = Professional fees-consultation  
 0989 = Professional fees-private duty nurse  
 0990 = Patient convenience items-general classification  
 0991 = Patient convenience items-cafeteria/guest tray  
 0992 = Patient convenience items-private linen service  
 0993 = Patient convenience items-telephone/telegraph  
 0994 = Patient convenience items-tv/radio  
 0995 = Patient convenience items-nonpatient room rentals  
 0996 = Patient convenience items-late discharge charge  
 0997 = Patient convenience items-admission kits  
 0998 = Patient convenience items-beauty shop/barber  
 0999 = Patient convenience items-other  
 1000 = Behavioral health Accommodations – general  
 1001 = Behavioral health Accommodations – residential treatment psychiatric  
 1002 = Behavioral health Accommodations – residential treatment chemical dependency  
 2101 = Alternative Therapy Services – Acupuncture  
 2103 = Alternative Therapy Services – Massage  
 3101 = Adult Day Care – Medical and Social (hourly)  
 3103 = Adult Day Care – Medical and Social (daily)  
 3104 = Adult Day Care –Social (daily)  
 3109 = Adult Day Care –other

NOTE: Following Revenue Codes reported for NHCMQ (RUGS) demo claims effective 2/96.

9000 = RUGS-no MDS assessment available  
 9001 = Reduced physical functions-RUGS PA1/ADL index of 4-5  
 9002 = Reduced physical functions-RUGS PA2/ADL index of 4-5  
 9003 = Reduced physical functions-RUGS PB1/ADL index of 6-8  
 9004 = Reduced physical functions-RUGS PB2/ADL index of 6-8  
 9005 = Reduced physical functions-RUGS PC1/ADL index of 9-10  
 9006 = Reduced physical functions-RUGS PC2/ADL index of 9-10  
 9007 = Reduced physical functions-RUGS PD1/ADL index of 11-15  
 9008 = Reduced physical functions-RUGS PD2/ADL index of 11-15  
 9009 = Reduced physical functions-RUGS PE1/ADL index of 16-18  
 9010 = Reduced physical functions-RUGS PE2/ADL index of 16-18  
 9011 = Behavior only problems-RUGS BA1/ADL index of 4-5  
 9012 = Behavior only problems-RUGS BA2/ADL index of 4-5  
 9013 = Behavior only problems-RUGS BB1/ADL index of 6-10  
 9014 = Behavior only problems-RUGS BB2/ADL index of 6-10  
 9015 = Impaired cognition-RUGS IA1/ADL index of 4-5  
 9016 = Impaired cognition-RUGS IA2/ADL index of 4-5  
 9017 = Impaired cognition-RUGS IB1/ADL index of 6-10

9018 = Impaired cognition-RUGS IB2/ADL index of 6-10  
 9019 = Clinically complex-RUGS CA1/ADL index of 4-5  
 9020 = Clinically complex-RUGS CA2/ADL index of 4-5d  
 9021 = Clinically complex-RUGS CB1/ADL index of 6-10  
 9022 = Clinically complex-RUGS CB2/ADL index of 6-10d  
 9023 = Clinically complex-RUGS CC1/ADL index of 11-16  
 9024 = Clinically complex-RUGS CC2/ADL index of 11-16d  
 9025 = Clinically complex-RUGS CD1/ADL index of 17-18  
 9026 = Clinically complex-RUGS CD2/ADL index of 17-18d  
 9027 = Special care-RUGS SSA/ADL index of 7-13  
 9028 = Special care-RUGS SSB/ADL index of 14-16  
 9029 = Special care-RUGS SSC/ADL index of 17-18  
 9030 = Extensive services-RUGS SE1/1 procedure  
 9031 = Extensive services-RUGS SE2/2 procedures  
 9032 = Extensive services-RUGS SE3/3 procedures  
 9033 = Low rehabilitation-RUGS RLA/ADL index of 4-11  
 9034 = Low rehabilitation-RUGS RLB/ADL index of 12-18  
 9035 = Medium rehabilitation-RUGS RMA/ADL index of 4-7  
 9036 = Medium rehabilitation-RUGS RMB/ADL index of 8-15  
 9037 = Medium rehabilitation-RUGS RMC/ADL index of 16-18  
 9038 = High rehabilitation-RUGS RHA/ADL index of 4-7  
 9039 = High rehabilitation-RUGS RHB/ADL index of 8-11  
 9040 = High rehabilitation-RUGS RHC/ADL index of 12-14  
 9041 = High rehabilitation-RUGS RHD/ADL index of 15-18  
 9042 = Very high rehabilitation-RUGS RVA/ADL index of 4-7  
 9043 = Very high rehabilitation-RUGS RVB/ADL index of 8-13  
 9044 = Very high rehabilitation-RUGS RVC/ADL index of 14-18

\*\*\*Changes effective for providers entering\*\*\*

\*\*RUGS Demo Phase III as of 1/1/97 or later\*\*

9019 = Clinically complex-RUGS CA1/ADL index of 11  
 9020 = Clinically complex-RUGS CA2/ADL index of 11D  
 9021 = Clinically complex-RUGS CB1/ADL index of 12-16  
 9022 = Clinically complex-RUGS CB2/ADL index of 12-16D  
 9023 = Clinically complex-RUGS CC1/ADL index of 17-18  
 9024 = Clinically complex-RUGS CC2/ADL index of 17-18D  
 9025 = Special care-RUGS SSA/ADL index of 14  
 9026 = Special care-RUGS SSB/ADL index of 15-16  
 9027 = Special care-RUGS SSC/ADL index of 17-18  
 9028 = Extensive services-RUGS SE1/ADL index 7-18/1 procedure  
 9029 = Extensive services-RUGS SE2/ADL index 7-18/2 procedures  
 9030 = Extensive services-RUGS SE3/ADL index 7-18/3 procedures  
 9031 = Low rehabilitation-RUGS RLA/ADL index of 4-13

9032 = Low rehabilitation-RUGS RLB/ADL index of 14-18  
9033 = Low rehabilitation-RUGS RLA/ADL index of 4-11  
9034 = Medium rehabilitation-RUGS RMB/ADL index of 8-14  
9035 = Medium rehabilitation-RUGS RMC/ADL index of 15-18  
9036 = High rehabilitation-RUGS RHA/ADL index of 4-7  
9037 = High rehabilitation-RUGS RHB/ADL index of 8-12  
9038 = High rehabilitation-RUGS RHC/ADL index of 13-18  
9039 = Very High rehabilitation-RUGS RVA/ADL index of 4-8  
9040 = Very high rehabilitation-RUGS RVB/ADL index of 9-15  
9041 = Very high rehabilitation-RUGS RVC/ADL index of 16  
9042 = Very high rehabilitation-RUGS RUA/ADL index of 4-8  
9043 = Very high rehabilitation-RUGS RUB/ADL index of 9-15  
9044 = Ultra high rehabilitation-RUGS RUC/ADL index of 16-18

**COMMENT:** -

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## REV\_CNTR\_1ST\_ANSI\_CD

**LABEL:** Revenue Center 1st ANSI Code

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

**SHORT NAME:** REVANSI1

**LONG NAME:** REV\_CNTR\_1ST\_ANSI\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** \*\*\*\*\*EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES\*\*\*\*\*  
\*\*\*\*\*POSITIONS 1 & 2 OF ANSI CODE\*\*\*\*\*

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

\*\*\*\*\*Claim Adjustment Reason Codes\*\*\*\*\*  
\*\*\*\*\*POSITIONS 3 through 5 of ANSI CODE\*\*\*\*\*

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider type.

- 9 = The diagnosis is inconsistent with the patient's age.
- 10 = The diagnosis is inconsistent with the patient's gender.
- 11 = The diagnosis is inconsistent with the procedure.
- 12 = The diagnosis is inconsistent with the provider type.
- 13 = The date of death precedes the date of service.
- 14 = The date of birth follows the date of service.
- 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 16 = Claim/service lacks information which is needed for adjudication.
- 17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
- 18 = Duplicate claim/service.
- 19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
- 20 = Claim denied because this injury/illness is covered by the liability carrier.
- 21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
- 22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
- 23 = Claim adjusted because charges have been paid by another payer.
- 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 25 = Payment denied. Your Stop loss deductible has not been met.
- 26 = Expenses incurred prior to coverage.
- 27 = Expenses incurred after coverage terminated.
- 28 = Coverage not in effect at the time the service was provided.
- 29 = The time limit for filing has expired.
- 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
- 31 = Claim denied as patient cannot be identified as our insured.
- 32 = Our records indicate that this dependent is not an eligible dependent as defined.
- 33 = Claim denied. Insured has no dependent coverage.
- 34 = Claim denied. Insured has no coverage for newborns.
- 35 = Benefit maximum has been reached.
- 36 = Balance does not exceed copayment amount.
- 37 = Balance does not exceed deductible amount.
- 38 = Services not provided or authorized by designated (network) providers.
- 39 = Services denied at the time authorization/pre-certification was requested.
- 40 = Charges do not meet qualifications for emergency/urgent care.
- 41 = Discount agreed to in Preferred Provider contract.
- 42 = Charges exceed our fee schedule or maximum allowable amount.
- 43 = Gramm-Rudman reduction.
- 44 = Prompt-pay discount.
- 45 = Charges exceed your contracted/legislated fee arrangement.

- 46 = This (these) service(s) is(are) not covered.
- 47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.
- 48 = This (these) procedure(s) is(are) not covered.
- 49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 51 = These are non-covered services because this a pre-existing condition.
- 52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
- 53 = Services by an immediate relative or a member of the same household are not covered.
- 54 = Multiple physicians/assistants are not covered in this case.
- 55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
- 56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
- 57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
- 58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- 59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 60 = Charges for outpatient services with the proximity to inpatient services are not covered.
- 61 = Charges adjusted as penalty for failure to obtain second surgical opinion.
- 62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.
- 63 = Correction to a prior claim. INACTIVE
- 64 = Denial reversed per Medical Review. INACTIVE
- 65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
- 66 = Blood Deductible.
- 67 = Lifetime reserve days. INACTIVE
- 68 = DRG weight. INACTIVE
- 69 = Day outlier amount.
- 70 = Cost outlier amount.
- 71 = Primary Payer amount.
- 72 = Coinsurance day. INACTIVE
- 73 = Administrative days. INACTIVE
- 74 = Indirect Medical Education Adjustment.
- 75 = Direct Medical Education Adjustment.
- 76 = Disproportionate Share Adjustment.
- 77 = Covered days. INACTIVE



- 78 = Non-covered days/room charge adjustment.
- 79 = Cost report days. INACTIVE
- 80 = Outlier days. INACTIVE
- 81 = Discharges. INACTIVE
- 82 = PIP days. INACTIVE
- 83 = Total visits. INACTIVE
- 84 = Capital adjustments. INACTIVE
- 85 = Interest amount. INACTIVE
- 86 = Statutory adjustment. INACTIVE
- 87 = Transfer amounts.
- 88 = Adjustment amount represents collection against receivable created in prior overpayment.
- 89 = Professional fees removed from charges.
- 90 = Ingredient cost adjustment.
- 91 = Dispensing fee adjustment.
- 92 = Claim paid in full. INACTIVE
- 93 = No claim level adjustment. INACTIVE
- 94 = Process in excess of charges.
- 95 = Benefits adjusted. Plan procedures not followed.
- 96 = Non-covered charges.
- 97 = Payment is included in allowance for another service/procedure.
- 98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE
- 99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
- 100 = Payment made to patient/insured/responsible party.
- 101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
- 102 = Major medical adjustment.
- 103 = Provider promotional discount (i.e. Senior citizen discount).
- 104 = Managed care withholding.
- 105 = Tax withholding.
- 106 = Patient payment option/election not in effect.
- 107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
- 108 = Claim/service reduced because rent/purchase guidelines were not met.
- 109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 110 = Billing date predates service date.
- 111 = Not covered unless the provider accepts assignment.
- 112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.
- 113 = Claim denied because service/procedure was provided outside the United States or as a result of war.
- 114 = Procedure/PRODUCT not approved by the Food and Drug Administration.

- 115 = Claim/service adjusted as procedure postponed or canceled.
- 116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
- 117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.
- 118 = Charges reduced for ESRD network support.
- 119 = Benefit maximum for this time period has been reached.
- 120 = Patient is covered by a managed care plan. INACTIVE
- 121 = Indemnification adjustment.
- 122 = Psychiatric reduction.
- 123 = Payer refund due to overpayment. INACTIVE
- 124 = Payer refund amount - not our patient. INACTIVE
- 125 = Claim/service adjusted due to a submission/billing error(s).
- 126 = Deductible - Major Medical.
- 127 = Coinsurance - Major Medical.
- 128 = Newborn's services are covered in the mother's allowance.
- 129 = Claim denied - prior processing information appears incorrect.
- 130 = Paper claim submission fee.
- 131 = Claim specific negotiated discount.
- 132 = Prearranged demonstration project adjustment.
- 133 = The disposition of this claim/service is pending further review.
- 134 = Technical fees removed from charges.
- 135 = Claim denied. Interim bills cannot be processed.
- 136 = Claim adjusted. Plan procedures of a prior payer were not followed.
- 137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
- 138 = Claim/service denied. Appeal procedures not followed or time limits not met.
- 139 = Contracted funding agreement - subscriber is employed by the provider of services.
- 140 = Patient/Insured health identification number and name do not match.
- 141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
- 142 = Claim adjusted by the monthly Medicaid patient liability amount.
- A0 = Patient refund amount
- A1 = Claim denied charges.
- A2 = Contractual adjustment.
- A3 = Medicare Secondary Payer liability met. INACTIVE
- A4 = Medicare Claim PPS Capital Day Outlier Amount.
- A5 = Medicare Claim PPS Capital Cost Outlier Amount.
- A6 = Prior hospitalization or 30 day transfer requirement not met.
- A7 = Presumptive Payment Adjustment.
- A8 = Claim denied; ungroupable DRG.
- B1 = Non-covered visits.
- B2 = Covered visits. INACTIVE

- B3 = Covered charges. INACTIVE
- B4 = Late filing penalty.
- B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
- B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.
- B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
- B9 = Services not covered because the patient is enrolled in a Hospice.
- B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
- B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
- B12 = Services not documented in patients' medical records.
- B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.
- B14 = Claim/service denied because only one visit or consultation per physician per day is covered.
- B15 = Claim/service adjusted because this procedure/service is not paid separately.
- B16 = Claim/service adjusted because 'New Patient' qualifications were not met.
- B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
- B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
- B19 = Claim/service adjusted because of the finding of a Review Organization.  
INACTIVE
- B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.
- B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE
- B22 = This claim/service is adjusted based on the diagnosis.
- B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.
- W1 = Workers Compensation State Fee Schedule Adjustment.

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07'

and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

Valid beginning with NCH weekly process date 7/7/00.

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## REV\_CNTR\_1ST\_MSP\_PD\_AMT

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Revenue Center 1st Medicare Secondary Payer (MSP) Paid Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>DESCRIPTION:</b> | The amount paid by the primary payer when the payer is primary to Medicare (Medicare is a secondary).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>SHORT NAME:</b>  | REV_MSP1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>LONG NAME:</b>   | REV_CNTR_1ST_MSP_PD_AMT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>COMMENT:</b>     | <p>This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPTS rules so those lines would not have data in this field.</p> <p>Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.</p> |

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## REV\_CNTR\_2ND\_ANSI\_CD

**LABEL:** Revenue Center 2nd ANSI Code

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

**SHORT NAME:** REVANSI2

**LONG NAME:** REV\_CNTR\_2ND\_ANSI\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** \*\*\*\*\*EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES\*\*\*\*\*  
\*\*\*\*\*POSITIONS 1 & 2 OF ANSI CODE\*\*\*\*\*

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

\*\*\*\*\*Claim Adjustment Reason Codes\*\*\*\*\*  
\*\*\*\*\*POSITIONS 3 through 5 of ANSI CODE\*\*\*\*\*

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider type.

- 9 = The diagnosis is inconsistent with the patient's age.
- 10 = The diagnosis is inconsistent with the patient's gender.
- 11 = The diagnosis is inconsistent with the procedure.
- 12 = The diagnosis is inconsistent with the provider type.
- 13 = The date of death precedes the date of service.
- 14 = The date of birth follows the date of service.
- 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 16 = Claim/service lacks information which is needed for adjudication.
- 17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
- 18 = Duplicate claim/service.
- 19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
- 20 = Claim denied because this injury/illness is covered by the liability carrier.
- 21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
- 22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
- 23 = Claim adjusted because charges have been paid by another payer.
- 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 25 = Payment denied. Your Stop loss deductible has not been met.
- 26 = Expenses incurred prior to coverage.
- 27 = Expenses incurred after coverage terminated.
- 28 = Coverage not in effect at the time the service was provided.
- 29 = The time limit for filing has expired.
- 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
- 31 = Claim denied as patient cannot be identified as our insured.
- 32 = Our records indicate that this dependent is not an eligible dependent as defined.
- 33 = Claim denied. Insured has no dependent coverage.
- 34 = Claim denied. Insured has no coverage for newborns.
- 35 = Benefit maximum has been reached.
- 36 = Balance does not exceed copayment amount.
- 37 = Balance does not exceed deductible amount.
- 38 = Services not provided or authorized by designated (network) providers.
- 39 = Services denied at the time authorization/pre-certification was requested.
- 40 = Charges do not meet qualifications for emergency/urgent care.
- 41 = Discount agreed to in Preferred Provider contract.
- 42 = Charges exceed our fee schedule or maximum allowable amount.
- 43 = Gramm-Rudman reduction.
- 44 = Prompt-pay discount.
- 45 = Charges exceed your contracted/legislated fee arrangement.

- 46 = This (these) service(s) is(are) not covered.
- 47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.
- 48 = This (these) procedure(s) is(are) not covered.
- 49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 51 = These are non-covered services because this a pre-existing condition.
- 52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
- 53 = Services by an immediate relative or a member of the same household are not covered.
- 54 = Multiple physicians/assistants are not covered in this case.
- 55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
- 56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
- 57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
- 58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- 59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 60 = Charges for outpatient services with the proximity to inpatient services are not covered.
- 61 = Charges adjusted as penalty for failure to obtain second surgical opinion.
- 62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.
- 63 = Correction to a prior claim. INACTIVE
- 64 = Denial reversed per Medical Review. INACTIVE
- 65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
- 66 = Blood Deductible.
- 67 = Lifetime reserve days. INACTIVE
- 68 = DRG weight. INACTIVE
- 69 = Day outlier amount.
- 70 = Cost outlier amount.
- 71 = Primary Payer amount.
- 72 = Coinsurance day. INACTIVE
- 73 = Administrative days. INACTIVE
- 74 = Indirect Medical Education Adjustment.
- 75 = Direct Medical Education Adjustment.
- 76 = Disproportionate Share Adjustment.
- 77 = Covered days. INACTIVE



- 78 = Non-covered days/room charge adjustment.
- 79 = Cost report days. INACTIVE
- 80 = Outlier days. INACTIVE
- 81 = Discharges. INACTIVE
- 82 = PIP days. INACTIVE
- 83 = Total visits. INACTIVE
- 84 = Capital adjustments. INACTIVE
- 85 = Interest amount. INACTIVE
- 86 = Statutory adjustment. INACTIVE
- 87 = Transfer amounts.
- 88 = Adjustment amount represents collection against receivable created in prior overpayment.
- 89 = Professional fees removed from charges.
- 90 = Ingredient cost adjustment.
- 91 = Dispensing fee adjustment.
- 92 = Claim paid in full. INACTIVE
- 93 = No claim level adjustment. INACTIVE
- 94 = Process in excess of charges.
- 95 = Benefits adjusted. Plan procedures not followed.
- 96 = Non-covered charges.
- 97 = Payment is included in allowance for another service/procedure.
- 98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE
- 99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
- 100 = Payment made to patient/insured/responsible party.
- 101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
- 102 = Major medical adjustment.
- 103 = Provider promotional discount (i.e. Senior citizen discount).
- 104 = Managed care withholding.
- 105 = Tax withholding.
- 106 = Patient payment option/election not in effect.
- 107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
- 108 = Claim/service reduced because rent/purchase guidelines were not met.
- 109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 110 = Billing date predates service date.
- 111 = Not covered unless the provider accepts assignment.
- 112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.
- 113 = Claim denied because service/procedure was provided outside the United States or as a result of war.
- 114 = Procedure/PRODUCT not approved by the Food and Drug Administration.

- 115 = Claim/service adjusted as procedure postponed or canceled.
- 116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
- 117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.
- 118 = Charges reduced for ESRD network support.
- 119 = Benefit maximum for this time period has been reached.
- 120 = Patient is covered by a managed care plan. INACTIVE
- 121 = Indemnification adjustment.
- 122 = Psychiatric reduction.
- 123 = Payer refund due to overpayment. INACTIVE
- 124 = Payer refund amount - not our patient. INACTIVE
- 125 = Claim/service adjusted due to a submission/billing error(s).
- 126 = Deductible - Major Medical.
- 127 = Coinsurance - Major Medical.
- 128 = Newborn's services are covered in the mother's allowance.
- 129 = Claim denied - prior processing information appears incorrect.
- 130 = Paper claim submission fee.
- 131 = Claim specific negotiated discount.
- 132 = Prearranged demonstration project adjustment.
- 133 = The disposition of this claim/service is pending further review.
- 134 = Technical fees removed from charges.
- 135 = Claim denied. Interim bills cannot be processed.
- 136 = Claim adjusted. Plan procedures of a prior payer were not followed.
- 137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
- 138 = Claim/service denied. Appeal procedures not followed or time limits not met.
- 139 = Contracted funding agreement - subscriber is employed by the provider of services.
- 140 = Patient/Insured health identification number and name do not match.
- 141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
- 142 = Claim adjusted by the monthly Medicaid patient liability amount.
- A0 = Patient refund amount
- A1 = Claim denied charges.
- A2 = Contractual adjustment.
- A3 = Medicare Secondary Payer liability met. INACTIVE
- A4 = Medicare Claim PPS Capital Day Outlier Amount.
- A5 = Medicare Claim PPS Capital Cost Outlier Amount.
- A6 = Prior hospitalization or 30 day transfer requirement not met.
- A7 = Presumptive Payment Adjustment.
- A8 = Claim denied; ungroupable DRG.
- B1 = Non-covered visits.
- B2 = Covered visits. INACTIVE

- B3 = Covered charges. INACTIVE
- B4 = Late filing penalty.
- B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
- B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.
- B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
- B9 = Services not covered because the patient is enrolled in a Hospice.
- B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
- B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
- B12 = Services not documented in patients' medical records.
- B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.
- B14 = Claim/service denied because only one visit or consultation per physician per day is covered.
- B15 = Claim/service adjusted because this procedure/service is not paid separately.
- B16 = Claim/service adjusted because 'New Patient' qualifications were not met.
- B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
- B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
- B19 = Claim/service adjusted because of the finding of a Review Organization.  
INACTIVE
- B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.
- B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE
- B22 = This claim/service is adjusted based on the diagnosis.
- B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.
- W1 = Workers Compensation State Fee Schedule Adjustment.

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07'

and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

Valid beginning with NCH weekly process date 7/7/00.

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## REV\_CNTR\_2ND\_MSP\_PD\_AMT

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Revenue Center 2nd Medicare Secondary Payer (MSP) Paid Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>DESCRIPTION:</b> | The amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>SHORT NAME:</b>  | REV_MSP2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>LONG NAME:</b>   | REV_CNTR_2ND_MSP_PD_AMT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>TYPE:</b>        | NUM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>LENGTH:</b>      | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>VALUES:</b>      | XXX.XX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>COMMENT:</b>     | <p>This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPTS rules so those lines would not have data in this field.</p> <p>Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.</p> |

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## REV\_CNTR\_3RD\_ANSI\_CD

**LABEL:** Revenue Center 3rd ANSI Code

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

**SHORT NAME:** REVANSI3

**LONG NAME:** REV\_CNTR\_3RD\_ANSI\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** \*\*\*\*\*EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES\*\*\*\*\*  
\*\*\*\*\*POSITIONS 1 & 2 OF ANSI CODE\*\*\*\*\*

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

\*\*\*\*\*Claim Adjustment Reason Codes\*\*\*\*\*  
\*\*\*\*\*POSITIONS 3 through 5 of ANSI CODE\*\*\*\*\*

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider type.

- 9 = The diagnosis is inconsistent with the patient's age.
- 10 = The diagnosis is inconsistent with the patient's gender.
- 11 = The diagnosis is inconsistent with the procedure.
- 12 = The diagnosis is inconsistent with the provider type.
- 13 = The date of death precedes the date of service.
- 14 = The date of birth follows the date of service.
- 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 16 = Claim/service lacks information which is needed for adjudication.
- 17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
- 18 = Duplicate claim/service.
- 19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
- 20 = Claim denied because this injury/illness is covered by the liability carrier.
- 21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
- 22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
- 23 = Claim adjusted because charges have been paid by another payer.
- 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 25 = Payment denied. Your Stop loss deductible has not been met.
- 26 = Expenses incurred prior to coverage.
- 27 = Expenses incurred after coverage terminated.
- 28 = Coverage not in effect at the time the service was provided.
- 29 = The time limit for filing has expired.
- 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
- 31 = Claim denied as patient cannot be identified as our insured.
- 32 = Our records indicate that this dependent is not an eligible dependent as defined.
- 33 = Claim denied. Insured has no dependent coverage.
- 34 = Claim denied. Insured has no coverage for newborns.
- 35 = Benefit maximum has been reached.
- 36 = Balance does not exceed copayment amount.
- 37 = Balance does not exceed deductible amount.
- 38 = Services not provided or authorized by designated (network) providers.
- 39 = Services denied at the time authorization/pre-certification was requested.
- 40 = Charges do not meet qualifications for emergency/urgent care.
- 41 = Discount agreed to in Preferred Provider contract.
- 42 = Charges exceed our fee schedule or maximum allowable amount.
- 43 = Gramm-Rudman reduction.
- 44 = Prompt-pay discount.
- 45 = Charges exceed your contracted/legislated fee arrangement.

- 46 = This (these) service(s) is(are) not covered.
- 47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.
- 48 = This (these) procedure(s) is(are) not covered.
- 49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 51 = These are non-covered services because this a pre-existing condition.
- 52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
- 53 = Services by an immediate relative or a member of the same household are not covered.
- 54 = Multiple physicians/assistants are not covered in this case.
- 55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
- 56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
- 57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
- 58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- 59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 60 = Charges for outpatient services with the proximity to inpatient services are not covered.
- 61 = Charges adjusted as penalty for failure to obtain second surgical opinion.
- 62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.
- 63 = Correction to a prior claim. INACTIVE
- 64 = Denial reversed per Medical Review. INACTIVE
- 65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
- 66 = Blood Deductible.
- 67 = Lifetime reserve days. INACTIVE
- 68 = DRG weight. INACTIVE
- 69 = Day outlier amount.
- 70 = Cost outlier amount.
- 71 = Primary Payer amount.
- 72 = Coinsurance day. INACTIVE
- 73 = Administrative days. INACTIVE
- 74 = Indirect Medical Education Adjustment.
- 75 = Direct Medical Education Adjustment.
- 76 = Disproportionate Share Adjustment.
- 77 = Covered days. INACTIVE



- 78 = Non-covered days/room charge adjustment.
- 79 = Cost report days. INACTIVE
- 80 = Outlier days. INACTIVE
- 81 = Discharges. INACTIVE
- 82 = PIP days. INACTIVE
- 83 = Total visits. INACTIVE
- 84 = Capital adjustments. INACTIVE
- 85 = Interest amount. INACTIVE
- 86 = Statutory adjustment. INACTIVE
- 87 = Transfer amounts.
- 88 = Adjustment amount represents collection against receivable created in prior overpayment.
- 89 = Professional fees removed from charges.
- 90 = Ingredient cost adjustment.
- 91 = Dispensing fee adjustment.
- 92 = Claim paid in full. INACTIVE
- 93 = No claim level adjustment. INACTIVE
- 94 = Process in excess of charges.
- 95 = Benefits adjusted. Plan procedures not followed.
- 96 = Non-covered charges.
- 97 = Payment is included in allowance for another service/procedure.
- 98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE
- 99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
- 100 = Payment made to patient/insured/responsible party.
- 101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
- 102 = Major medical adjustment.
- 103 = Provider promotional discount (i.e. Senior citizen discount).
- 104 = Managed care withholding.
- 105 = Tax withholding.
- 106 = Patient payment option/election not in effect.
- 107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
- 108 = Claim/service reduced because rent/purchase guidelines were not met.
- 109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 110 = Billing date predates service date.
- 111 = Not covered unless the provider accepts assignment.
- 112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.
- 113 = Claim denied because service/procedure was provided outside the United States or as a result of war.
- 114 = Procedure/PRODUCT not approved by the Food and Drug Administration.

- 115 = Claim/service adjusted as procedure postponed or canceled.
- 116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
- 117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.
- 118 = Charges reduced for ESRD network support.
- 119 = Benefit maximum for this time period has been reached.
- 120 = Patient is covered by a managed care plan. INACTIVE
- 121 = Indemnification adjustment.
- 122 = Psychiatric reduction.
- 123 = Payer refund due to overpayment. INACTIVE
- 124 = Payer refund amount - not our patient. INACTIVE
- 125 = Claim/service adjusted due to a submission/billing error(s).
- 126 = Deductible - Major Medical.
- 127 = Coinsurance - Major Medical.
- 128 = Newborn's services are covered in the mother's allowance.
- 129 = Claim denied - prior processing information appears incorrect.
- 130 = Paper claim submission fee.
- 131 = Claim specific negotiated discount.
- 132 = Prearranged demonstration project adjustment.
- 133 = The disposition of this claim/service is pending further review.
- 134 = Technical fees removed from charges.
- 135 = Claim denied. Interim bills cannot be processed.
- 136 = Claim adjusted. Plan procedures of a prior payer were not followed.
- 137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
- 138 = Claim/service denied. Appeal procedures not followed or time limits not met.
- 139 = Contracted funding agreement - subscriber is employed by the provider of services.
- 140 = Patient/Insured health identification number and name do not match.
- 141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
- 142 = Claim adjusted by the monthly Medicaid patient liability amount.
- A0 = Patient refund amount
- A1 = Claim denied charges.
- A2 = Contractual adjustment.
- A3 = Medicare Secondary Payer liability met. INACTIVE
- A4 = Medicare Claim PPS Capital Day Outlier Amount.
- A5 = Medicare Claim PPS Capital Cost Outlier Amount.
- A6 = Prior hospitalization or 30 day transfer requirement not met.
- A7 = Presumptive Payment Adjustment.
- A8 = Claim denied; ungroupable DRG.
- B1 = Non-covered visits.
- B2 = Covered visits. INACTIVE

- B3 = Covered charges. INACTIVE
- B4 = Late filing penalty.
- B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
- B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.
- B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
- B9 = Services not covered because the patient is enrolled in a Hospice.
- B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
- B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
- B12 = Services not documented in patients' medical records.
- B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.
- B14 = Claim/service denied because only one visit or consultation per physician per day is covered.
- B15 = Claim/service adjusted because this procedure/service is not paid separately.
- B16 = Claim/service adjusted because 'New Patient' qualifications were not met.
- B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
- B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
- B19 = Claim/service adjusted because of the finding of a Review Organization.  
INACTIVE
- B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.
- B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE
- B22 = This claim/service is adjusted based on the diagnosis.
- B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.
- W1 = Workers Compensation State Fee Schedule Adjustment.

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07'

and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

Valid beginning with NCH weekly process date 7/7/00.

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## REV\_CNTR\_4TH\_ANSI\_CD

**LABEL:** Revenue Center 4th ANSI Code

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

**SHORT NAME:** REVANSI4

**LONG NAME:** REV\_CNTR\_4TH\_ANSI\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** \*\*\*\*\*EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES\*\*\*\*\*  
\*\*\*\*\*POSITIONS 1 & 2 OF ANSI CODE\*\*\*\*\*

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

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OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

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PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

\*\*\*\*\*Claim Adjustment Reason Codes\*\*\*\*\*  
\*\*\*\*\*POSITIONS 3 through 5 of ANSI CODE\*\*\*\*\*

1 = Deductible Amount

2 = Coinsurance Amount

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4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider type.

- 9 = The diagnosis is inconsistent with the patient's age.
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- 11 = The diagnosis is inconsistent with the procedure.
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- 13 = The date of death precedes the date of service.
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- 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 16 = Claim/service lacks information which is needed for adjudication.
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- 29 = The time limit for filing has expired.
- 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
- 31 = Claim denied as patient cannot be identified as our insured.
- 32 = Our records indicate that this dependent is not an eligible dependent as defined.
- 33 = Claim denied. Insured has no dependent coverage.
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- 63 = Correction to a prior claim. INACTIVE
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- 68 = DRG weight. INACTIVE
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- 74 = Indirect Medical Education Adjustment.
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- 78 = Non-covered days/room charge adjustment.
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- 93 = No claim level adjustment. INACTIVE
- 94 = Process in excess of charges.
- 95 = Benefits adjusted. Plan procedures not followed.
- 96 = Non-covered charges.
- 97 = Payment is included in allowance for another service/procedure.
- 98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE
- 99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
- 100 = Payment made to patient/insured/responsible party.
- 101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
- 102 = Major medical adjustment.
- 103 = Provider promotional discount (i.e. Senior citizen discount).
- 104 = Managed care withholding.
- 105 = Tax withholding.
- 106 = Patient payment option/election not in effect.
- 107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
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- 109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 110 = Billing date predates service date.
- 111 = Not covered unless the provider accepts assignment.
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- 139 = Contracted funding agreement - subscriber is employed by the provider of services.
- 140 = Patient/Insured health identification number and name do not match.
- 141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
- 142 = Claim adjusted by the monthly Medicaid patient liability amount.
- A0 = Patient refund amount
- A1 = Claim denied charges.
- A2 = Contractual adjustment.
- A3 = Medicare Secondary Payer liability met. INACTIVE
- A4 = Medicare Claim PPS Capital Day Outlier Amount.
- A5 = Medicare Claim PPS Capital Cost Outlier Amount.
- A6 = Prior hospitalization or 30 day transfer requirement not met.
- A7 = Presumptive Payment Adjustment.
- A8 = Claim denied; ungroupable DRG.
- B1 = Non-covered visits.
- B2 = Covered visits. INACTIVE

- B3 = Covered charges. INACTIVE
- B4 = Late filing penalty.
- B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
- B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.
- B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
- B9 = Services not covered because the patient is enrolled in a Hospice.
- B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
- B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
- B12 = Services not documented in patients' medical records.
- B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.
- B14 = Claim/service denied because only one visit or consultation per physician per day is covered.
- B15 = Claim/service adjusted because this procedure/service is not paid separately.
- B16 = Claim/service adjusted because 'New Patient' qualifications were not met.
- B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
- B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
- B19 = Claim/service adjusted because of the finding of a Review Organization.  
INACTIVE
- B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.
- B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE
- B22 = This claim/service is adjusted based on the diagnosis.
- B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.
- W1 = Workers Compensation State Fee Schedule Adjustment.

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07'

and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

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Valid beginning with NCH weekly process date 7/7/00.

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## REV\_CNTR\_APC\_HIPPS\_CD

**LABEL:** Revenue Center APC or HIPPS Code

**DESCRIPTION:** This field contains one of two potential pieces of data; the Ambulatory Payment Classification (APC) code or the Health Insurance Prospective Payment System (HIPPS) code, which corresponds with the revenue center line for the claim.

The APC codes are used as the basis for payment for outpatient prospective payment (OPPS) service (e.g., Part B institutional).

Some Part A claim types (e.g., home health and SNF) use resource groupings, which are similar to case-mix groups, as the basis for payment (e.g., HHRG, SNF RUGs).

For home health (HH) claims, when the revenue center code (variable called REV\_CNTR) is 0023, the HHRG is located in this field and is a HIPPS code. This field is only meaningful for a HH claim when CMS determines the claim should be paid using a different HIPPS code than the one submitted by the provider. When this happens, the revised HIPPS code (the one actually used for payment purposes) appears in this field and the original HIPPS code submitted by the provider remains in the HCPCS\_CD field. Otherwise, this variable will always be null or have a value of "00000" for HH revenue center records.

The resource utilization group for the particular revenue center is located in the data field called the APC or HIPPS code variable.

The APC is a four byte field.

The HIPPS code is a five byte field (such as 1AFKS).

**SHORT NAME:** APCHIPPS

**LONG NAME:** REV\_CNTR\_APC\_HIPPS\_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** APC codes are shown below; HIPPS codes can be downloaded from the CMS website Prospective Payment Systems page (see: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html>).

0000 = Code used when Payment Method Indicator equals 'N9'

0001 = Photochemotherapy

0002 = Fine needle Biopsy/Aspiration

0003 = Bone Marrow Biopsy/Aspiration

0004 = Level I Needle Biopsy/ Aspiration Except Bone Marrow

0005 = Level II Needle Biopsy /Aspiration Except Bone Marrow

0006 = Level I Incision & Drainage

0007 = Level II Incision & Drainage

0008 = Level III Incision & Drainage  
 0009 = Nail Procedures  
 0010 = Level I Destruction of Lesion  
 0011 = Level II Destruction of Lesion  
 0012 = Level I Debridement & Destruction  
 0013 = Level II Debridement & Destruction  
 0014 = Level III Debridement & Destruction  
 0015 = Level IV Debridement & Destruction  
 0016 = Level V Debridement & Destruction  
 0017 = Level VI Debridement & Destruction  
 0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane  
 0019 = Level I Excision/ Biopsy  
 0020 = Level II Excision/ Biopsy  
 0021 = Level III Excision/ Biopsy  
 0022 = Level IV Excision/ Biopsy  
 0023 = Exploration Penetrating Wound  
 0024 = Level I Skin Repair  
 0025 = Level II Skin Repair  
 0026 = Level III Skin Repair  
 0027 = Level IV Skin Repair  
 0028 = Level I Incision/Excision Breast  
 0029 = Incision/Excision Breast (obsolete 12/00); Level II Incision/Excision Breast  
       Effective 1/01)  
 0030 = Breast Reconstruction/Mastectomy  
 0031 = Hyperbaric Oxygen (obsolete 1/01)  
 0032 = Placement Transvenous Catheters/Arterial Cutdown  
 0033 = Partial Hospitalization  
 0040 = Arthrocentesis & Ligament/Tendon Injection  
 0041 = Arthroscopy  
 0042 = Arthroscopically-Aided Procedures  
 0043 = Closed Treatment Fracture Finger/Toe/Trunk  
 0044 = Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk  
 0045 = Bone/Joint Manipulation Under Anesthesia  
 0046 = Open/Percutaneous Treatment Fracture or Dislocation  
 0047 = Arthroplasty without Prosthesis  
 0048 = Arthroplasty with Prosthesis  
 0049 = Level I Musculoskeletal Procedures Except Hand and Foot  
 0050 = Level II Musculoskeletal Procedures Except Hand and Foot  
 0051 = Level III Musculoskeletal Procedures Except Hand and Foot  
 0052 = Level IV Musculoskeletal Procedures Except Hand and Foot  
 0053 = Level I Hand Musculoskeletal Procedures  
 0054 = Level II Hand Musculoskeletal Procedures  
 0055 = Level I Foot Musculoskeletal Procedures  
 0056 = Level II Foot Musculoskeletal Procedures

0057 = Bunion Procedures  
 0058 = Level I Strapping and Cast Application  
 0059 = Level II Strapping and Cast Application  
 0060 = Manipulation Therapy  
 0070 = Thoracentesis/Lavage Procedures  
 0071 = Level I Endoscopy Upper Airway  
 0072 = Level II Endoscopy Upper Airway  
 0073 = Level III Endoscopy Upper Airway  
 0074 = Level IV Endoscopy Upper Airway  
 0075 = Level V Endoscopy Upper Airway  
 0076 = Endoscopy Lower Airway  
 0077 = Level I Pulmonary Treatment  
 0078 = Level II Pulmonary Treatment  
 0079 = Ventilation Initiation and Management  
 0080 = Diagnostic Cardiac Catheterization  
 0081 = Non-Coronary Angioplasty or Atherectomy  
 0082 = Coronary Atherectomy  
 0083 = Coronary Angioplasty  
 0084 = Level I Electrophysiologic Evaluation  
 0085 = Level II Electrophysiologic Evaluation  
 0086 = Ablate Heart Dysrhythm Focus  
 0087 = Cardiac Electrophysiologic Recording/Mapping  
 0088 = Thrombectomy  
 0089 = Level I Implantation/Removal/Revision of Pacemaker, AICD Vascular Device  
 (obsolete 12/00); Insertion/Replacement of Permanent Pacemaker and  
 Electrodes (eff. 1/01)  
 0090 = Level II Implantation/Removal/Revision of Pacemaker AICD Vascular Device  
 (obsolete 12/00); Insertion/Replacement of Permanent Pacemaker and Pulse  
 Generator  
 0091 = Level I Vascular Ligation  
 0092 = Level II Vascular Ligation  
 0093 = Vascular Repair/Fistula Construction  
 0094 = Resuscitation and Cardioversion  
 0095 = Cardiac Rehabilitation  
 0096 = Non-Invasive Vascular Studies  
 0097 = Cardiovascular Stress Test (obsolete 12/00); Cardiac Monitoring for 30 days (eff.  
 1/01)  
 0098 = Injection of Sclerosing Solution  
 0099 = Continuous Cardiac Monitoring (obsolete 12/00); Electrocardiograms (eff. 1/01)  
 0100 = Stress test and continuous ECG  
 0101 = Tilt Table Evaluation  
 0102 = Electronic Analysis of Pacemakers/other Devices  
 0103 = Miscellaneous Vascular Procedures (eff. 1/01)  
 0104 = Transcatheter Placement of Intracoronary Stents (eff. 1/01)

0105 = Revision/Removal of Pacemakers, AICD or Vascular (eff. 1/01)  
 0106 = Insertion/Replacement/Repair of Pacemaker Electrode (eff. 1/01)  
 0107 = Insertion of Cardioverter-Defibrillator (eff. 1/01)  
 0108 = Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads (eff. 1/01)  
 0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant (obsolete  
 12/00); Removal of Implanted Devices (eff. 1/01)  
 0110 = Transfusion  
 0111 = Blood PROduct Exchange  
 0112 = Extracorporeal Photopheresis  
 0113 = Excision Lymphatic System  
 0114 = Thyroid/Lymphadenectomy Procedures  
 0115 = Cannula/Access Device Procedures (eff. 1/01)  
 0116 = Chemotherapy Administration by Other Technique Except Infusion  
 0117 = Chemotherapy Administration by Infusion Only  
 0118 = Chemotherapy Administration by Both Infusion and Other Technique  
 0119 = Implantation of Devices (eff. 1/01)  
 0120 = Infusion Therapy Except Chemotherapy  
 0121 = Level I Tube changes and Repositioning  
 0122 = Level II Tube changes and Repositioning  
 0123 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant  
 0124 = Revision of Implanted Infusion Pump (eff. 1/01)  
 0130 = Level I Laparoscopy  
 0131 = Level II Laparoscopy  
 0132 = Level III Laparoscopy  
 0140 = Esophageal Dilation without Endoscopy  
 0141 = Upper GI Procedures  
 0142 = Small Intestine Endoscopy  
 0143 = Lower GI Endoscopy  
 0144 = Diagnostic Anoscopy  
 0145 = Therapeutic Anoscopy  
 0146 = Level I Sigmoidoscopy  
 0147 = Level II Sigmoidoscopy  
 0148 = Level I Anal/Rectal Procedure  
 0149 = Level II Anal/Rectal Procedure  
 0150 = Level III Anal/Rectal Procedure  
 0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)  
 0152 = Percutaneous Biliary Endoscopic Procedures  
 0153 = Peritoneal and Abdominal Procedures  
 0154 = Hernia/Hydrocele Procedures  
 0157 = Colorectal Cancer Screening: Barium Enema (Not subject to National  
 coinsurance)  
 0158 = Colorectal Cancer Screening: Colonoscopy Not subject to National coinsurance.  
 Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is  
 lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy Not subject to National coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

0160 = Level I Cystourethroscopy and other Genitourinary Procedures

0161 = Level II Cystourethroscopy and other Genitourinary Procedures

0162 = Level III Cystourethroscopy and other Genitourinary Procedures

0163 = Level IV Cystourethroscopy and other Genitourinary Procedures

0164 = Level I Urinary and Anal Procedures

0165 = Level II Urinary and Anal Procedures

0166 = Level I Urethral Procedures

0167 = Level II Urethral Procedures

0168 = Level III Urethral Procedures

0169 = Lithotripsy

0170 = Dialysis for Other Than ESRD Patients

0180 = Circumcision

0181 = Penile Procedures

0182 = Insertion of Penile Prosthesis

0183 = Testes/Epididymis Procedures

0184 = Prostate Biopsy

0190 = Surgical Hysteroscopy

0191 = Level I Female RePRODuctive Procedures

0192 = Level II Female RePRODuctive Procedures

0193 = Level III Female RePRODuctive Procedures

0194 = Level IV Female RePRODuctive Procedures

0195 = Level V Female RePRODuctive Procedures

0196 = Dilatation & Curettage

0197 = Infertility Procedures

0198 = Pregnancy and Neonatal Care Procedures

0199 = Vaginal Delivery

0200 = Therapeutic Abortion

0201 = Spontaneous Abortion

0210 = Spinal Tap

0211 = Level I Nervous System Injections

0212 = Level II Nervous System Injections

0213 = Extended EEG Studies and Sleep Studies

0214 = Electroencephalogram

0215 = Level I Nerve and Muscle Tests

0216 = Level II Nerve and Muscle Tests

0217 = Level III Nerve and Muscle Tests

0220 = Level I Nerve Procedures

0221 = Level II Nerve Procedures

0222 = Implantation of Neurological Device



0223 = Level I Revision/Removal Neurological Device (obsolete 12/00); Implantation of Pain Management Device (eff. 1/01)  
 0224 = Level II Revision/Removal Neurological Device (obsolete 12/00); Implantation of Reservoir/Pump/Shunt (eff. 1/01)  
 0225 = Implantation of Neurostimulator Electrodes  
 0226 = Implantation of Drug Infusion Reservoir (eff. 1/01)  
 0227 = Implantation of Drug Infusion Device (eff. 1/01)  
 0228 = Creation of Lumbar Subarachnoid Shunt (eff. 1/01)  
 0229 = Transcatheter Placement of Intravascular Shunts (eff. 1/01)  
 0230 = Level I Eye Tests  
 0231 = Level II Eye Tests  
 0232 = Level I Anterior Segment Eye  
 0233 = Level II Anterior Segment Eye  
 0234 = Level III Anterior Segment Eye Procedures  
 0235 = Level I Posterior Segment Eye Procedures  
 0236 = Level II Posterior Segment Eye Procedures  
 0237 = Level III Posterior Segment Eye Procedures  
 0238 = Level I Repair and Plastic Eye Procedures  
 0239 = Level II Repair and Plastic Eye Procedures  
 0240 = Level III Repair and Plastic Eye Procedures  
 0241 = Level IV Repair and Plastic Eye Procedures  
 0242 = Level V Repair and Plastic Eye Procedures  
 0243 = Strabismus/Muscle Procedures  
 0244 = Corneal Transplant  
 0245 = Cataract Procedures without IOL Insert  
 0246 = Cataract Procedures with IOL Insert  
 0247 = Laser Eye Procedures Except Retinal  
 0248 = Laser Retinal Procedures  
 0250 = Nasal Cauterization/Packing  
 0251 = Level I ENT Procedures  
 0252 = Level II ENT Procedures  
 0253 = Level III ENT Procedures  
 0254 = Level IV ENT Procedures  
 0256 = Level V ENT Procedures  
 0257 = Implantation of Cochlear Device (obsolete 1/01)  
 0258 = Tonsil and Adenoid Procedures  
 0260 = Level I Plain Film Except Teeth  
 0261 = Level II Plain Film Except Teeth Including Bone Density Measurement  
 0262 = Plain Film of Teeth  
 0263 = Level I Miscellaneous Radiology Procedures  
 0264 = Level II Miscellaneous Radiology Procedures  
 0265 = Level I Diagnostic Ultrasound Except Vascular  
 0266 = Level II Diagnostic Ultrasound Except Vascular  
 0267 = Vascular Ultrasound

0268 = Guidance Under Ultrasound  
 0269 = Echocardiogram Except Transesophageal  
 0270 = Transesophageal Echocardiogram  
 0271 = Mammography  
 0272 = Level I Fluoroscopy  
 0273 = Level II Fluoroscopy  
 0274 = Myelography  
 0275 = Arthrography  
 0276 = Level I Digestive Radiology  
 0277 = Level II Digestive Radiology  
 0278 = Diagnostic Urography  
 0279 = Level I Diagnostic Angiography and Venography Except Extremity  
 0280 = Level II Diagnostic Angiography and Venography Except Extremity  
 0281 = Venography of Extremity  
 0282 = Level I Computerized Axial Tomography  
 0283 = Level II Computerized Axial Tomography  
 0284 = Magnetic Resonance Imaging  
 0285 = Positron Emission Tomography (PET)  
 0286 = Myocardial Scans  
 0290 = Standard Non-Imaging Nuclear Medicine  
 0291 = Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans  
 0292 = Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans  
 0294 = Level I Therapeutic Nuclear Medicine  
 0295 = Level II Therapeutic Nuclear Medicine  
 0296 = Level I Therapeutic Radiologic Procedures  
 0297 = Level II Therapeutic Radiologic Procedures  
 0300 = Level I Radiation Therapy  
 0301 = Level II Radiation Therapy  
 0302 = Level III Radiation Therapy  
 0303 = Treatment Device Construction  
 0304 = Level I Therapeutic Radiation Treatment Preparation  
 0305 = Level II Therapeutic Radiation Treatment Preparation  
 0310 = Level III Therapeutic Radiation Treatment Preparation  
 0311 = Radiation Physics Services  
 0312 = Radioelement Applications  
 0313 = Brachytherapy  
 0314 = Hyperthermic Therapies  
 0320 = Electroconvulsive Therapy  
 0321 = Biofeedback and Other Training  
 0322 = Brief Individual Psychotherapy  
 0323 = Extended Individual Psychotherapy  
 0324 = Family Psychotherapy  
 0325 = Group Psychotherapy  
 0330 = Dental Procedures

0340 = Minor Ancillary Procedures  
 0341 = Immunology Tests  
 0342 = Level I Pathology  
 0343 = Level II Pathology  
 0344 = Level III Pathology  
 0345 = Transfusion Laboratory Procedures Level I (eff. 1/01)  
 0346 = Transfusion Laboratory Procedures Level II (eff. 1/01)  
 0347 = Transfusion Laboratory Procedures Level III (eff. 1/01)  
 0348 = Fertility Laboratory Procedures (eff. 1/01)  
 0349 = Miscellaneous Laboratory Procedures (eff. 1/01)  
 0354 = Administration of Influenza Vaccine (Not subject to national coinsurance)  
 0355 = Level I Immunizations  
 0356 = Level II Immunizations  
 0357 = Level III Immunizations (obsolete 1/01)  
 0358 = Level IV Immunizations (obsolete 1/01)  
 0359 = Injections  
 0360 = Level I Alimentary Tests  
 0361 = Level II Alimentary Tests  
 0362 = Fitting of Vision Aids  
 0363 = Otorhinolaryngologic Function Tests  
 0364 = Level I Audiometry  
 0365 = Level II Audiometry  
 0366 = Electrocardiogram (ECG) (obsolete 1/01)  
 0367 = Level I Pulmonary Test  
 0368 = Level II Pulmonary Test  
 0369 = Level III Pulmonary Test  
 0370 = Allergy Tests  
 0371 = Allergy Injections  
 0372 = Therapeutic Phlebotomy  
 0373 = Neuropsychological Testing  
 0374 = Monitoring Psychiatric Drugs  
 0600 = Low Level Clinic Visits  
 0601 = Mid Level Clinic Visits  
 0602 = High Level Clinic Visits  
 0603 = Interdisciplinary Team Conference (obsolete 1/01)  
 0610 = Low Level Emergency Visits  
 0611 = Mid Level Emergency Visits  
 0612 = High Level Emergency Visits  
 0620 = Critical Care  
 0701 = Strontium (eligible for pass-through payments) (obsolete 12/00); SR 89 chloride,  
       per mCi (eff. 1/01)  
 0702 = Samarium (eligible for pass-through payments) (obsolete 12/00); SM 153  
       lexidronam, 50 mCi (eff. 1/01)  
 0704 = IN 111 Satumomab Pendetide (eligible for pass-through payments)

0705 = Tc99 Tetrofosmin (eligible for pass-through payments)  
 0725 = Leucovorin Calcium (eligible for pass-through payments)  
 0726 = Dexrazoxane Hydrochloride (eligible for pass-through payments)  
 0727 = Injection, Etidronate Disodium (eligible for pass-through payments)  
 0728 = Filgrastim (G-CSF) (eligible for pass-through payments)  
 0730 = Pamidronate Disodium (eligible for pass-through payments)  
 0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)  
 0732 = Mesna (eligible for pass-through payments)  
 0733 = Non-ESRD Epoetin Alpha (eligible for pass-through payments)  
 0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)  
 0754 = Metoclopramide HCL (eligible for pass-through payments)  
 0755 = Thiethylperazine Maleate (eligible for pass-through payments)  
 0761 = Oral Substitute for IV Antiemetic (eligible for pass-through payments)  
 0762 = Dronabinol (eligible for pass-through payments)  
 0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)  
 0764 = Granisetron HCL, 100 mcg (eligible for pass-through payments)  
 0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)  
 0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)  
 0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)  
 0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)  
 0801 = Cyclophosphamide (eligible for pass-through payments)  
 0802 = Etoposide (eligible for pass-through payments)  
 0803 = Melphalan (eligible for pass-through payments)  
 0807 = Aldesleukin single use vial (eligible for pass-through payments)  
 0809 = BCG (Intravesical) one vial (eligible for pass-through payments)  
 0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)  
 0811 = Carboplatin 50 mg (eligible for pass-through payments)  
 0812 = Carmustine 100 mg (eligible for pass-through payments)  
 0813 = Cisplatin 10 mg (eligible for pass-through payments)  
 0814 = Asparaginase, 10,000 units (eligible for pass-through payments)  
 0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)  
 0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)  
 0817 = Cytrabine 100 mg (eligible for pass-through payments)  
 0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)  
 0819 = Dacarbazine 100 mg (eligible for pass-through payments)  
 0820 = Daunorubicin HCl 10 mg (eligible for pass-through payments)  
 0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)  
 0822 = Diethylstilbestrol Diphosphate 250 mg (eligible for pass-through payments)  
 0823 = Docetaxel 20 mg (eligible for pass-through payments)  
 0824 = Etoposide 10 mg (eligible for pass-through payments)  
 0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)  
 0827 = Floxuridine injection 500mg

0828 = Gemcitabine HCL 200 mg (eligible for pass-through payments)  
 0830 = Irinotecan 20 mg (eligible for pass-through payments)  
 0831 = Ifosfamide injection 1 gm (eligible for pass-through payments)  
 0832 = Idarubicin HCL injection 5 mg (eligible for pass-through payments)  
 0833 = Interferon Alfacon-1, 1 mcg (eligible for pass-through payments)  
 0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)  
 0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)  
 0838 = Interferon, Gamma 1-B injection, 3 million units (eligible for pass-through payments)  
 0839 = Mechlorethamine HCL injection 10 mg (eligible for pass-through payments)  
 0840 = Melphalan HCL 50 mg (eligible for pass-through payments)  
 0841 = Methotrexate sodium injection 5 mg (eligible for pass-through payments)  
 0842 = Fludarabine Phosphate injection 50 mg (eligible for pass-through payments)  
 0843 = Pegaspargase, single dose vial (eligible for pass-through payments)  
 0844 = Pentostatin injection, 10 mg (eligible for pass-through payments)  
 0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)  
 0849 = Rituximab, 100 mg (eligible for pass-through payments)  
 0850 = Streptozocin injection, 1 gm (eligible for pass-through payments)  
 0851 = Thiotepa injection, 15 mg (eligible for pass-through payments)  
 0852 = Topotecan 4 mg (eligible for pass-through payments)  
 0853 = Vinblastine Sulfate injection, 1 mg (eligible for pass-through payments)  
 0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments)  
 0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)  
 0856 = Porfimer Sodium 75 mg (eligible for pass-through payments)  
 0857 = Bleomycin Sulfate injection 15 units (eligible for pass-through payments)  
 0858 = Cladribine, 1mg (eligible for pass-through payments)  
 0859 = Fluorouracil injection 500 mg  
 0860 = Plicamycin (mithramycin) injection, 2.5 mg  
 0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)  
 0862 = Mitomycin, 5mg (eligible for pass-through payments)  
 0863 = Paclitaxel, 30mg (eligible for pass-through payments)  
 0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments)  
 0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)  
 0884 = Rho (D) Immune Globulin, Human one dose pack (eligible for pass-through payments)  
 0886 = Azathioprine, 50 mg oral (Not subject to national coinsurance)  
 0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection (Not subject to national coinsurance)  
 0888 = Cyclosporine, Oral 100 mg (Not subject to national coinsurance)  
 0889 = Cyclosporine, Parenteral (Not subject to national coinsurance)  
 0890 = Lymphocyte Immune Globulin 250 mg (Not subject to national coinsurance)  
 0891 = Tacrolimus per 1 mg oral (Not subject to national coinsurance)

0892 = Daclizumab, Parenteral, 25 mg (obsolete 1/01) (eligible for pass-through payments)

0900 = Injection, Alglucerase per 10 units (eligible for pass-through payments)

0901 = Alpha I, Proteinase Inhibitor, Human per 10mg (eligible for pass-through payments)

0902 = Botulinum Toxin, Type A per unit (eligible for pass-through payments)

0903 = CMV Immune Globulin (obsolete 12/00); Cytomegalovirus imm IV, vial (eligible for pass-through payments) (eff. 1/01)

0905 = Immune Globulin per 500 mg (eligible for pass-through payments)

0906 = RSV-ivig 50 mg (eligible for pass-through payments)

0907 = Ganciclovir Sodium 500 mg injection (Not subject to national coinsurance)

0908 = Tetanus Immune Globulin, injection up to 250 units (Not subject to national coinsurance)

0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)

0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)

0911 = Streptokinase per 250,000 iu (Not subject to national coinsurance)

0913 = Ganciclovir long act implant 4.5 mg (eligible for pass-through payments)

0914 = Reteplase, 37.6 mg (Not subject to national coinsurance)

0915 = Alteplase injection, recombinant, 10mg (Not subject to national coinsurance)

0916 = Imiglucerase per unit (eligible for pass-through payments)

0917 = Dipyridamole, 10mg / Adenosine 6MG (Not subject to national coinsurance) (obsolete 1/01) Pharmacologic stresses (eff. 1/01)

0918 = Brachytherapy Seeds, Any type, Each (eligible for pass-through payments) (obsolete 4/01)

0925 = Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)

0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)

0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)

0928 = Factor IX, Complex (eligible for pass-through payments)

0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments) (obsolete 1/01) Anti-inhibitor per iu (eff. 1/01)

0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)

0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)

0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)

0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)

0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)

0952 = Cryoprecipitate (not subject to national coinsurance)

0953 = Fibrinogen Unit (not subject to national coinsurance)

0954 = Leukocyte Poor Blood (not subject to national coinsurance)

0955 = Plasma, Fresh Frozen (not subject to national coinsurance)  
 0956 = Plasma Protein Fraction (not subject to national coinsurance)  
 0957 = Platelet Concentrate (not subject to national coinsurance)  
 0958 = Platelet Rich Plasma (not subject to national coinsurance)  
 0959 = Red Blood Cells (not subject to national coinsurance)  
 0960 = Washed Red Blood Cells (not subject to national coinsurance)  
 0961 = Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)  
 0962 = Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)  
 0970 = New Technology - Level I (\$0 - \$50) (not subject to national coinsurance)  
 0971 = New Technology - Level II (\$50 - \$100) (not subject to national coinsurance)  
 0972 = New Technology - Level III (\$100 - \$200) (not subject to national coinsurance)  
 0973 = New Technology - Level IV (\$200 - \$300) (not subject to national coinsurance)  
 0974 = New Technology - Level V (\$300 - \$500) (not subject to national coinsurance)  
 0975 = New Technology - Level VI (\$500 - \$750) (not subject to national coinsurance)  
 0976 = New Technology - Level VII (\$750 - \$1000) (not subject to national coinsurance)  
 0977 = New Technology - Level VIII (\$1000 - \$1250) (not subject to national coinsurance)  
 0978 = New Technology - Level IX (\$1250 - \$1500) (not subject to national coinsurance)  
 0979 = New Technology - Level X (\$1500 - \$1750) (not subject to national coinsurance)  
 0980 = New Technology - Level XI (\$1750 - \$2000) (not subject to national coinsurance)  
 0981 = New Technology - Level XII (\$2000 - \$2500) (not subject to national coinsurance)  
 0982 = New Technology - Level XIII (\$2500 - \$3500) (not subject to national coinsurance)  
 0983 = New Technology - Level XIV (\$3500 - \$5000) (not subject to national coinsurance)  
 0984 = New Technology - Level XV (\$5000 - \$6000) (not subject to national coinsurance)  
 0987 = New Device Technology - Level I (\$0 - \$250) (eff. 1/01)  
 0988 = New Device Technology - Level II (\$250 - \$500) (eff. 1/01)  
 0989 = New Device Technology - Level III (\$500 - \$750) (eff. 1/01)  
 0990 = New Device Technology - Level IV (\$750 - \$1000) (eff. 1/01)  
 0991 = New Device Technology - Level V (\$1000 - \$1500) (eff. 1/01)  
 0992 = New Device Technology - Level VI (\$1500 - \$2000) (eff. 1/01)  
 0993 = New Device Technology - Level VII (\$2000 - \$3000) (eff. 1/01)  
 0994 = New Device Technology - Level VIII (\$3000 - \$4000) (eff. 1/01)  
 0995 = New Device Technology - Level IX (\$4000 - \$5000) (eff. 1/01)  
 0996 = New Device Technology - Level X (\$5000 - \$7000) (eff. 1/01)  
 0997 = New Device Technology - Level XI (\$7000 - \$9000) (eff. 1/01)  
 1000 = Perclose Closer Prostar Arterial Vascular Closure (eff. 1/01)  
 1001 = AcuNav-diagnostic ultrasound ca (eff. 1/01)  
 1002 = Cochlear Implant System (eff. 1/01)  
 1003 = Cath, ablation, livewire TC (eff. 1/01)  
 1004 = Fast-Cath, Swartz, SAFL, CSTA (eff. 1/01)  
 1006 = ARRAY post chamb IOL (eff. 1/01) 1007 = Ams 700 penile prosthesis (eff. 1/01)  
 1008 = Urolume-implant urethral stent (eff. 1/01)

1009 = Plasma, cryoprecipitate-reduced, unit (eff. 1/01)  
 1010 = Blood, L/R CMV-neg (eff. 1/01)  
 1011 = Platelets, L/R, CMV-neg (eff. 1/01)  
 1012 = Platelet concentrate, L/R, irradiated, unit (eff. 1/01)  
 1013 = Platelet concentrate, L/R, unit (eff. 1/01)  
 1014 = Platelets, aph/pher, L/R, unit (eff. 1/01)  
 1016 = Blood, L/R, froz/deglycerol/washed (eff. 1/01)  
 1017 = Platelets, aph/pher, L/R CMV-neg, unit (eff. 1/01)  
 1018 = Blood, L/R, irradiated (eff. 1/01)  
 1019 = Platelets, aph/pher, L/R, irradiated, unit (eff. 1/01)  
 1024 = Quinupristin 150 mg/dalfopriston 350 mg (eff. 1/01)  
 1025 = Marinr CS catheter (eff. 1/01)  
 1026 = RF Perfrmr cath 5F RF Marinr (eff. 1/01)  
 1027 = Magic x/short, radius 14m (eff. 1/01)  
 1028 = Prcis Twst trnsvg anch sys (eff. 1/01)  
 1029 = CRE guided balloon dil cath (eff. 1/01)  
 1030 = Cthtr:Mrshal, Blu Max Utr Dmnd (eff. 1/01)  
 1033 = Sonicath mdl 37-410 (eff. 1/01)  
 1034 = SURPASS, Long30 SURPASS-cath (eff. 1/01)  
 1035 = Cath, Ultra ICE (eff. 1/01)  
 1036 = R port/reservior impl dev (eff. 1/01)  
 1037 = Vaxcelchronic dialysis cath (eff. 1/01)  
 1038 = UltraCross Imaging Cath (eff. 1/01)  
 1039 = Wallstent/RP:Trach (eff. 1/01)  
 1040 = Wallstent/RP TIPS -- 20/40/60 (eff. 1/01)  
 1042 = Wallstent, UltraFlex: Bil (eff. 1/01)  
 1045 = I-131 MIBG (ioben-sulfate) 0.5 mCi (eff. 1/01)  
 1047 = Navi-Star, Noga-Star cath (eff. 1/01)  
 1048 = NeuroCyberneticPros: gen (eff. 1/01)  
 1051 = Oasis Thrombectomy Cath (eff. 1/01)  
 1053 = EnSite 3000 catheter (eff. 1/01)  
 1054 = Hydrolyser Thromb Cath 6/7F (eff. 1/01)  
 1055 = Transesoph 210, 210-S Cath (eff. 1/01)  
 1056 = Thermachoice II Cath (eff. 1/01)  
 1057 = Micromark Tissue Marker (eff. 1/01)  
 1059 = Carticel, auto cult-chndr cyte (eff. 1/01)  
 1060 = ACS multi-link tristor stent (eff. 1/01)  
 1061 = ACS Viking Guiding cath (eff. 1/01)  
 1063 = EndoTak Endurance EZ, RX leads (eff. 1/01)  
 1067 = Megalink biliary stent (eff. 1/01)  
 1068 = Pulsar DDD pmkr (eff. 1/01)  
 1069 = Discovery DR, pmaker  
 1071 = Pulsar Max, Pulsar SR pmkr (eff. 1/01)  
 1072 = Guidant: blin dil cath (eff. 1/01)



1073 = Gynecare Morcellator (eff. 1/01)  
 1074 = RX/OTW Viatrac-peri dil cath (eff. 1/01)  
 1075 = Guidant: lead (eff. 1/01)  
 1076 = Ventak minisc defib (eff. 1/01)  
 1077 = Ventak VR Prizm VR, sc defib (eff. 1/01)  
 1078 = Ventak: Prizm, AVIIIDR defib  
 1079 = CO 57/58 0.5 mCi (eff. 1/01)  
 1084 = Denileukin diftiox, 300 mcg (eff. 1/01)  
 1086 = Temozolomide, 5 mg (eff. 1/01)  
 1087 = I-123 per uCi capsule (eff. 1/01)  
 1089 = CO 57, 0.5 mCi (eff. 1/01)  
 1090 = IN 111 Chloride, per mCi (eff. 1/01)  
 1091 = IN 111 Oxyquinoline, per 5 mCi (eff. 1/01)  
 1092 = IN 111 Pentetate, per 1.5 mCi (eff. 1/01)  
 1094 = TC 99M Albumin aggr, per vial  
 1095 = TC 99M Depreotide, per vial (eff. 1/01)  
 1096 = TC 99M Exametazime, per dose (eff. 1/01)  
 1097 = TC 99M Mebrofenin, per vial (eff. 1/01)  
 1098 = TC 99M Pentetate, per vial (eff. 1/01)  
 1099 = TC 99M Pyrophosphate, per vial (eff. 1/01)  
 1100 = Medtronic AVE GT1 guidewire (eff. 1/01)  
 1101 = Medtronic AVE, AVE Z2 cath (eff. 1/01)  
 1102 = Synergy Neurostim Genrtr (eff. 1/01)  
 1103 = Micro Jewell Defibrillator (eff. 1/01)  
 1104 = RF ConductorAblative Cath (eff. 1/01)  
 1105 = Sigman 300VDD pacmkr (eff. 1/01)  
 1106 = SynergyEZ Pt Progmr (eff. 1/01)  
 1107 = Torqr, Solist cath (eff. 1/01)  
 1108 = Reveal Cardiac Recorder (eff. 1/01)  
 1109 = Implantable anchor: Ethicon (eff. 1/01)  
 1110 = Stable Mapper, cath electrd (eff. 1/01)  
 1111 = AneuRxAort-Uni-Ilicstnt & cath (eff. 1/01)  
 1112 = AneuRx Stent graft/del cath (eff. 1/01)  
 1113 = Tlnt Endo Sprng Stnt Grft Sys (eff. 1/01)  
 1114 = TalntSprgStnt + Graf endo pros (eff. 1/01)  
 1115 = 5038S, 5038, 5038L pace lead (eff. 1/01)  
 1116 = CapSureSP pacing lead (eff. 1/01)  
 1117 = Ancure Endograft Del Sys (eff. 1/01)  
 1118 = Sigma300DR LegIIDR, pacemkr (eff. 1/01)  
 1119 = Sprint6932, 6943 defib lead (eff. 1/01)  
 1120 = Sprint6942, 6945 defi lead (eff. 1/01)  
 1121 = Gem defibrillator (eff. 1/01)  
 1122 = TC 99M arcitumomab per dose (eff. 1/01)  
 1123 = Gem II VR defibrillator (eff. 1/01)

1124 = InterStim Test Stim Kit (eff. 1/01)  
 1125 = Kappa 400SR, Ttopaz II SR pmkr (eff. 1/01)  
 1126 = Kappa 700 DR pacemkr (eff. 1/01)  
 1127 = Kappa 700SR, pmkr sgl chamber (eff. 1/01)  
 1128 = Kappa 700D, Ruby IID pmkr (eff. 1/01)  
 1129 = Kappa 700VDD, pacmkr (eff. 1/01)  
 1130 = Sigma 200D, LGCY IID sc pmkr (eff. 1/01)  
 1131 = Sigma 200DR pmker (eff. 1/01)  
 1132 = Sigma 200SR Leg II:sc pac (eff. 1/01)  
 1133 = Sigma SR, Vita SR, pmaker (eff. 1/01)  
 1134 = Sigma 300D pmker (eff. 1/01)  
 1135 = Entity DR 5326L/R, DC, pmkr (eff. 1/01)  
 1136 = Affinity DR 5330L/R, DC, pmkr (eff. 1/01)  
 1137 = CardioSEAL implant syst (eff. 1/01)  
 1143 = AddVent mod 2060BL, VDD (eff. 1/01)  
 1144 = Afnty SP 5130, Integrity SR, pmkr (eff. 1/01)  
 1145 = Angio-Seal 6fr, 8fr (eff. 1/01)  
 1147 = AV Plus DX 1368: lead (eff. 1/01)  
 1148 = Contour MD sc defib (eff. 1/01)  
 1149 = Entity DC 5226R-pmker (eff. 1/01)  
 1151 = Passiveplus DXlead, 10mdls (eff. 1/01)  
 1152 = LifeSite Access System (eff. 1/01)  
 1153 = Regency SC+ 2402L pmkr (eff. 1/01)  
 1154 = SPL:SPOI, 0204- defib lead (eff. 1/01)  
 1155 = Repliform 8 sq cm (eff. 1/01)  
 1156 = Tr 1102TrSR+ 2260L, 2264L, 5131 (eff. 1/01)  
 1157 = Trilogy DCT 23/8L pmkr (eff. 1/01)  
 1158 = TVL lead SV01, SV02, SV04 (eff. 1/01)  
 1159 = TVL RV02, RV06, RV07: lead (eff. 1/01)  
 1160 = TVL-ADX 1559: lead (eff. 1/01)  
 1161 = Tendril DX, 1338 pacing lead (eff. 1/01)  
 1162 = TempoDr, TrilogyDR+ DC pmkr (eff. 1/01)  
 1163 = Tendril SDX, 1488T pacing lead (eff. 1/01)  
 1164 = Iodine-125 brachytx seed (eff. 1/01)  
 1166 = Cytarabine liposomal, 10 mg (eff. 1/01)  
 1167 = Epirubicin hcl, 2 mg (eff. 1/01)  
 1171 = Autosuture site marker stple (eff. 1/01)  
 1172 = Spacemaker dissect ballon (eff. 1/01)  
 1173 = Cor stntS540, S670, o-wire stn (eff. 1/01)  
 1174 = Bard brachytx needle (eff. 1/01)  
 1178 = Busulfan IV, 6 mg (eff. 1/01)  
 1180 = Vigor SR, SC, pmkr (eff. 1/01)  
 1181 = Meridian SSI, SC pmkr (eff. 1/01)  
 1182 = Pulsar SSI, SC, pmkr (eff. 1/01)

1183 = Jade IIS, Sigma 300S, SC, pmkr (eff. 1/01)  
 1184 = Sigma 200S, SC, pmkr (eff. 1/01)  
 1188 = I 131, per mCi (eff. 1/01)  
 1200 = TC 99M Sodium Clucoheptonate, per vial (eff. 1/01)  
 1201 = TC 99M succimer, per vial (eff. 1/01)  
 1202 = TC 99M Sulfur Colloid, per dose (eff. 1/01)  
 1203 = Verteporfin for Injection (eff. 1/01)  
 1205 = TC 99M Disofenin, per vial (eff. 1/01)  
 1207 = Octreotide acetate depot 1 mg (eff. 1/01)  
 1302 = SQ01:lead (eff. 1/01)  
 1303 = CapSure Fix 6940/4068-110, lead (eff. 1/01)  
 1304 = Sonicath mdl 37-416,-418 (eff. 1/01)  
 1305 = Apligraf (eff. 1/01)  
 1306 = NeuroCyberneticsPros: lead (eff. 1/01)  
 1311 = Trilogy DR + DAO pmkr (eff. 1/01)  
 1312 = Magic WALLSTENT stent-mini (eff. 1/01)  
 1313 = Magic medium, radius 31mm (eff. 1/01)  
 1314 = Magic WALLSTENT stent-Long (eff. 1/01)  
 1315 = Vigor DR, Meridian DR pmkr (eff. 1/01)  
 1316 = Meridian DDD pmkr (eff. 1/01)  
 1317 = Discovery SR, pmkr (eff. 1/01)  
 1318 = Meridian SR pmkr (eff. 1/01)  
 1319 = Wallstent/RP Enteral--60mm (eff. 1/01)  
 1320 = Wallstent/RP Iliac Del Sys (eff. 1/01)  
 1325 = Pallidium - 103 seed (eff. 1/01)  
 1326 = Angio-jet rheolytic thromb cath (eff. 1/01)  
 1328 = ANS Renew NS trnsmt (eff. 1/01)  
 1333 = PALMZA Corinthian bill stent (eff. 1/01)  
 1334 = Crown, Mini-crown,CrossLC (eff. 1/01)  
 1335 = Mesh, Prolene (eff. 1/01)  
 1336 = Constant Flow Imp Pump (eff. 1/01)  
 1337 = IsoMed 8472-20/35/60 (eff. 1/01)  
 1348 = I 131 per mCi solution (eff. 1/01)  
 1350 = Prosta/OncoSeed, RAPID strand, I-125 (eff. 1/01)  
 1351 = CapSure (Fix) pacing lead (eff. 1/01)  
 1352 = Gem II defib (eff. 1/01)  
 1353 = Itrel Interstm neurostim + ext (eff. 1/01)  
 1354 = Kappa 400DR, Diamond II 820 DR (eff. 1/01)  
 1355 = Kappa 600 DR, Vita DR (eff. 1/01)  
 1356 = Profile MD V-186HV3 sc defib (eff. 1/01)  
 1357 = Angstrom MD V-190HV3 sc defib (eff. 1/01)  
 1358 = Affinity DC 5230R-Pacemaker (eff. 1/01)  
 1359 = Pulsar, Pulsar Max DR, pmkr (eff. 1/01)  
 1363 = Gem DR, DC, defib (eff. 1/01)

1364 = Photon DR V-230HV3 DC defib (eff. 1/01)  
 1365 = Guidewire, Hi-Torque 14/18/35 (eff. 1/01)  
 1366 = Guidewire, PTCA, Hi-Torque (eff. 1/01)  
 1367 = Guidewire, Hi-Torque Crosslt (eff. 1/01)  
 1369 = ANS Renew Stim Sys recvr (eff. 1/01)  
 1370 = Tension-Free Vaginal Tape (eff. 1/01)  
 1371 = Symp Nitinol Transhep Bil Sys (eff. 1/01)  
 1372 = Cordis Nitinol bil Stent (eff. 1/01)  
 1375 = Stent, coronary, NIR (eff. 1/01)  
 1376 = ANS Renew Stim Sys lead (eff. 1/01)  
 1377 = Specify 3988 neuro lead (eff. 1/01)  
 1378 = InterStim Tx 3080/3886 lead (eff. 1/01)  
 1379 = Pisces-Quad 3887 lead (eff. 1/01)  
 1400 = Diphenhydramine hcl 50 mg (eff. 1/01)  
 1401 = Prochlorperazine maleate 5 mg (eff. 1/01)  
 1402 = Promethazine hcl 12.5 mg oral (eff. 1/01)  
 1403 = Chlorpromazine hcl 10mg oral (eff. 1/01)  
 1404 = Trimethobenzamide hcl 250mg (eff. 1/01)  
 1405 = Thiethylperazine maleate 10 mg (eff. 1/01)  
 1406 = Perphenazine 4 mg oral (eff. 1/01)  
 1407 = Hydroxyzine pamoate 25 mg (eff. 1/01)  
 1409 = Factor via recombinant, per 1.2 mg (eff. 1/01)  
 1410 = Prosorba column (eff. 1/01)  
 1411 = Herculink, OTW SDS bil stent (eff. 1/01)  
 1420 = StapleTac2 Bone w/Dermis (eff. 1/01)  
 1421 = StapleTac2 Bone w/o Dermis (eff. 1/01)  
 1450 = Orthosphere Arthroplasty (eff. 1/01)  
 1451 = Orthosphere Arthroplasty Kity (eff. 1/01)  
 1500 = Atherectomy sys, peripheral (eff. 1/01)  
 1600 = TC 99M sestamibi, per syringe (eff. 1/01)  
 1601 = TC 99M medronate, per dose (eff. 1/01)  
 1602 = TC 99M apcitide, per vial (eff. 1/01)  
 1603 = TL 201, mCi (eff. 1/01)  
 1604 = IN 111 capromab pendetide, per dose (eff. 1/01)  
 1605 = Abciximab injection, 10 mg (eff. 1/01)  
 1606 = Anistreplase, 30 u (eff. 1/01)  
 1607 = Eptifibatide injection, 5 mg (eff. 1/01)  
 1608 = Etanercept injection, 25 mg (eff. 1/01)  
 1609 = Rho(D) Immune globulin h, sd 100 iu (eff. 1/01)  
 1611 = Hylan G-F 20 injection, 16 mg (eff. 1/01)  
 1612 = Daclizumab, parenteral, 25 mg (eff. 1/01)  
 1613 = Trastuzumab, 10 mg (eff. 1/01)  
 1614 = Valrubicin, 200 mg (eff. 1/01)  
 1615 = Basiliximab, 20 mg (eff. 1/01)

1616 = Histrelin Acetate, 0.5 mg (eff. 1/01)  
 1617 = Lepirdin, 50 mg (eff. 1/01)  
 1618 = Von Willebrand factor, per iu (eff. 1/01)  
 1619 = Ga 67, per mCi (eff. 1/01)  
 1620 = TC 99M Bicisate, per vial (eff. 1/01)  
 1621 = Xe 133, per mCi (eff. 1/01)  
 1622 = TC 99M Mertiatide, per vial (eff. 1/01)  
 1623 = TC 99M Gluceptate (eff. 1/01)  
 1624 = P32 sodium, per mCi (eff. 1/01)  
 1625 = IN 111 Pentetreotide, per mCi (eff. 1/01)  
 1626 = TC 99M Oxidronate, per vial (eff. 1/01)  
 1627 = TC-99 labeled red blood cell, per test (eff. 1/01)  
 1628 = P32 phosphate chromic, per mCi (eff. 1/01)  
 1700 = Authen Mick TP brachy needle (eff. 1/01) (obsolete 4/01)  
 1701 = Medtec MT-BT-5201-25 ndl (eff. 1/01) (obsolete 4/01)  
 1702 = WWMT brachytx needle (eff. 1/01) (obsolete 4/01)  
 1703 = Mentor Prostate Brachy (eff. 1/01) (obsolete 4/01)  
 1704 = MT-BT-5001-25/5051-25 (eff. 1/01) (obsolete 4/01)  
 1705 = Best Flexi Brachy Needle (eff. 1/01) (obsolete 4/01)  
 1706 = Indigo Prostate Seeding Ndl (eff. 1/01) (obsolete 4/01)  
 1707 = Varisource Implt Ndl (eff. 1/01) (obsolete 4/01)  
 1708 = UroMed Prostate Seed Ndl (eff. 1/01) (obsolete 4/01)  
 1709 = Remington Brachytx Needle (eff. 1/01) (obsolete 4/01)  
 1710 = US Biopsy Prostate Needle (eff. 1/01) (obsolete 4/01)  
 1711 = MD Tech brachytx needle (eff. 1/01) (obsolete 4/01)  
 1712 = Imagyn brachytx needle (eff. 1/01) (obsolete 4/01)  
 1713 = Anchor/screw bn/bn,tis/bn (eff. 4/01)  
 1714 = Cath, trans atherectomy, dir (eff. 4/01)  
 1715 = Brachytherapy needle (eff. 4/01)  
 1716 = Brachytx seed, Gold 198 (eff. 4/01)  
 1717 = Brachytx seed, HDR Ir-192 (eff. 4/01)  
 1718 = Brachytx seed, Iodine 125 (eff. 4/01)  
 1719 = Brachytx seed, Non-HDR Ir-192 (eff. 4/01)  
 1720 = Brachytx, Palladium 103 (eff. 4/01)  
 1721 = AICD, dual chamber (eff. 4/01)  
 1722 = AICD, single chamber (eff. 4/01)  
 1723 = Cath, ablation, non-cardiac (eff. 4/01)  
 1724 = Cath, trans atherec, rotation (eff. 4/01)  
 1725 = Cath, translumin non-laser (eff. 4/01)  
 1726 = Cath, bal dil, non-vascular (eff. 4/01)  
 1727 = Cath, bal tis, dis, nonvas (eff. 4/01)  
 1728 = Cath, brachytx seed adm (eff. 4/01)  
 1729 = Cath, drainage, biliary (eff. 4/01)  
 1730 = Cath, EP, 19 or fewer elect (eff. 4/01)

1731 = Cath, EP, 20 or more elect (eff. 4/01)  
 1732 = Cath, EP, diag/abl, 3D/vect (eff. 4/01)  
 1733 = Cath, EP, other than temp (eff. 4/01)  
 1750 = Cath, hemodialysis, long-term (eff. 4/01)  
 1751 = Cath, inf pr/cent/midline (eff. 4/01)  
 1752 = Cath, hemodialysis, short-term (eff. 4/01)  
 1753 = Cath, intravas ultrasound (eff. 4/01)  
 1754 = Catheter, intradiscal (eff. 4/01)  
 1755 = Catheter, intraspinal (eff. 4/01)  
 1756 = Cath, pacing, transesoph (eff. 4/01)  
 1757 = Cath, thrombectomy/embolect (eff. 4/01)  
 1758 = Cath, ureteral (eff. 4/01)  
 1759 = Cath, intra echocardiography (eff. 4/01)  
 1760 = Closure dev, vasc, imp/insert (eff. 4/01)  
 1762 = Conn tiss, human (inc fascia) (eff. 4/01)  
 1763 = Conn tiss, non-human (eff. 4/01)  
 1764 = Event recorder, cardiac (eff. 4/01)  
 1767 = Generator, neurostim, imp (eff. 4/01)  
 1768 = Graft, vascular (eff. 4/01)  
 1769 = Guide wire (eff. 4/01)  
 1770 = Imaging coil, MR insertable (eff. 4/01)  
 1771 = Rep dev, urinary, w/sling (eff. 4/01)  
 1772 = Infusion pump, programmable (eff. 4/01)  
 1773 = Retrieval dev, insert (eff. 4/01)  
 1776 = Joint device (implantable) (eff. 4/01)  
 1777 = Lead, AICD, endo single coil (eff. 4/01)  
 1778 = Lead, neurostimulator (eff. 4/01)  
 1779 = Lead, pmkr, transvenous VDD (eff. 4/01)  
 1780 = Lens, intraocular (eff. 4/01)  
 1781 = Mesh (implantable) (eff. 4/01)  
 1782 = Morcellator (eff. 4/01)  
 1784 = Ocular dev, intraop, det ret (eff. 4/01)  
 1785 = Pmkr, dual, rate-resp (eff. 4/01)  
 1786 = Pmkr, single, rate-resp (eff. 4/01)  
 1787 = Patient progr, neurostim (eff. 4/01)  
 1788 = Port, indwelling, imp (eff. 4/01)  
 1789 = Prosthesis, breast, imp. (eff. 4/01)  
 1790 = Iridium 192 HDR (eff. 1/01) (obsolete 4/01)  
 1791 = OncoSeed, Rapid Strand I-125 (eff. 1/01) (obsolete 4/01)  
 1792 = UroMed I-125 Brachy seed (eff. 1/01) (obsolete 4/01)  
 1793 = Bard InterSource P-103 seed (eff. 1/01) (obsolete 4/01)  
 1794 = Bard IsoSeed P-103 seed (eff. 1/01) (obsolete 4/01)  
 1795 = Bard BrachySource I-125 (eff. 1/01) (obsolete 4/01)  
 1796 = Source Tech Med I-125 (eff. 1/01) (obsolete 4/01)

1797 = Draximage I-125 seed (eff. 1/01) (obsolete 4/01)  
 1798 = Syncor I-125 PharmaSeed (eff. 1/01) (obsolete 4/01)  
 1799 = I-Plant I-125 Brachytx seed (eff. 1/01) (obsolete 4/01)  
 1800 = Pd-103 brachytx seed (eff. 1/01) (obsolete 4/01)  
 1801 = IoGold I-125 brachytx seed (eff. 1/01) (obsolete 4/01)  
 1802 = Iridium 192 brachytx seed (eff. 1/01) (obsolete 4/01)  
 1803 = Best Iodine 125 brachytx seeds (eff. 1/01) (obsolete 4/01)  
 1804 = Best Palladium 103 seeds (eff. 1/01) (obsolete 4/01)  
 1805 = IsoStar Iodine-125 seeds (eff. 1/01) (obsolete 4/01)  
 1806 = Gold 198 (eff. 1/01) (obsolete 4/01)  
 1810 = D114S Dilatation Cath (eff. 1/01) (obsolete 4/01)  
 1811 = Surgical Dynamics Anchors (eff. 1/01) (obsolete 4/01)  
 1812 = OBL Anchors (eff. 1/01) (obsolete 4/01)  
 1813 = Prosthesis, penile, inflatab (eff. 4/01)  
 1815 = Pros, urinary sph, imp (eff. 4/01)  
 1816 = Receiver/transmitter, neuro (eff. 4/01)  
 1817 = Septal defect imp sys (eff. 4/01)  
 1850 = Repliform 14/21 sq cm (eff. 1/01) (obsolete 4/01)  
 1851 = Repliform 24/28 sq cm (eff. 1/01) (obsolete 4/01)  
 1852 = TransCyte, per 247 sq cm (eff. 1/01) (obsolete 4/01)  
 1853 = Suspend, per 8/14 sq cm (eff. 1/01) (obsolete 4/01)  
 1854 = Suspend, per 24/28 sq cm (eff. 1/01) (obsolete 4/01)  
 1855 = Suspend, per 36 sq cm (eff. 1/01) (obsolete 4/01)  
 1856 = Suspend, per 48 sq cm (eff. 1/01) (obsolete 4/01)  
 1857 = Suspend, per 84 sq cm (eff. 1/01) (obsolete 4/01)  
 1858 = DuraDerm, per 8/14 sq cm (eff. 1/01) (obsolete 4/01)  
 1859 = DuraDerm, per 21/24 sq cm (eff. 1/01) (obsolete 4/01)  
 1860 = DuraDerm, per 48 sq cm (eff. 1/01) (obsolete 4/01)  
 1861 = DuraDerm, per 36 sq cm (eff. 1/01) (obsolete 4/01)  
 1862 = DuraDerm, per 72 sq cm (eff. 1/01) (obsolete 4/01)  
 1863 = DuraDerm, per 84 sq cm (eff. 1/01) (obsolete 4/01)  
 1864 = SpermaTex, per 13/44 sq cm (eff. 1/01) (obsolete 4/01)  
 1865 = FasLata, per 8/14 sq cm (eff. 1/01) (obsolete 4/01)  
 1866 = FasLata, per 24/28 sq cm (eff. 1/01) (obsolete 4/01)  
 1867 = FasLata, per 36/48 sq cm (eff. 1/01) (obsolete 4/01)  
 1868 = FasLata, per 96 sq cm (eff. 1/01) (obsolete 4/01)  
 1869 = Gore Thyroplasty Dev (eff. 1/01) (obsolete 4/01)  
 1870 = DermMatrix, per 16 sq cm (eff. 1/01) (obsolete 4/01)  
 1871 = DermMatrix, 32 or 64 sq cm (eff. 1/01) (obsolete 4/01)  
 1872 = Dermagraft, per 37.5 sq cm (eff. 1/01) (obsolete 4/01)  
 1873 = Bard 3DMax Mesh (eff. 1/01) (obsolete 4/01)  
 1874 = Stent, coated/cov w/del sys (eff. 4/01)  
 1875 = Stent, coated/cov w/o del sys (eff. 4/01)  
 1876 = Stent, non-coated/no-cov w/del (eff. 4/01)

1877 = Stent, non-coated/cov w/o del (eff. 4/01)  
 1878 = Martl for vocal cord (eff. 4/01)  
 1879 = Tissue marker, imp (eff. 4/01)  
 1880 = Vena cava filter (eff. 4/01)  
 1881 = Dialysis access system (eff. 4/01)  
 1882 = AICD, other than sing/dual (eff. 4/01)  
 1883 = Adapt/ext, pacing/neuro lead (eff. 4/01)  
 1885 = Cath, translumin angio laser (eff. 4/01)  
 1887 = Catheter, guiding (eff. 4/01)  
 1891 = Infusion pump, non-prog, perm (eff. 4/01)  
 1892 = Intro/sheath, fixed, peel-away (eff. 4/01)  
 1893 = Intro/sheath, fixed, non-peel (eff. 4/01)  
 1894 = Intro/sheath, non-laser (eff. 4/01)  
 1895 = Lead, AICD, endo dual coil (eff. 4/01)  
 1896 = Lead, AICD, non sing/dual (eff. 4/01)  
 1897 = Lead, neurostim test kit (eff. 4/01)  
 1898 = Lead, pmkr, other than trans (eff. 4/01)  
 1899 = Lead, pmkr/AICD combination (eff. 4/01)  
 1929 = Maverick PTCA Cath (eff. 1/01) (obsolete 4/01)  
 1930 = Coyote Dil Cath, 20/30/40mm (eff. 1/01) (obsolete 4/01)  
 1931 = Talon Dil Cath (eff. 1/01) (obsolete 4/01)  
 1932 = Scimed remedy Dil Cath (eff. 1/01) (obsolete 4/01)  
 1933 = Opti-Plast XL/Centurion Cath (eff. 1/01) (obsolete 4/01)  
 1934 = Ultraverse 3.5F Bal Dil Cath (eff. 1/01) (obsolete 4/01)  
 1935 = Workhorse PTA Bal Cath (eff. 1/01) (obsolete 4/01)  
 1936 = Uromax Ultra Bal Dil Cath (eff. 1/01) (obsolete 4/01)  
 1937 = Synergy Balloon Dil Cath (eff. 1/01) (obsolete 4/01)  
 1938 = Uroforce Bal Dil Cath (eff. 1/01) (obsolete 4/01)  
 1939 = Raptur, Ninja PTCA Dil Cath (eff. 1/01) (obsolete 4/01)  
 1940 = PowerFlex, OPTA 5/LP Bal Cath (eff. 1/01) (obsolete 4/01)  
 1941 = Jupiter PTA Dil Cath (eff. 1/01) (obsolete 4/01)  
 1942 = Cordis Maxi LD PTA Bal Cath (eff. 1/01) (obsolete 4/01)  
 1943 = RXCrossSail OTW OpenSail (eff. 1/01) (obsolete 4/01)  
 1944 = Rapid Exchange Bil Dil Cath (eff. 1/01) (obsolete 4/01)  
 1945 = Savvy PTA Dil Cath (eff. 1/01) (obsolete 4/01)  
 1946 = R1s Rapid Dil Cath (eff. 1/01) (obsolete 4/01)  
 1947 = Gazelle Bal Dil Cath (eff. 1/01) (obsolete 4/01)  
 1948 = Pursuit Balloon Cath (eff. 1/01) (obsolete 4/01)  
 1949 = Oracle Megasonics Cath (eff. 1/01) (obsolete 4/01)  
 1979 = Visions PV/Avanar US Cath (eff. 1/01) (obsolete 4/01)  
 1980 = Atlantis SR Coronary Cath (eff. 1/01) (obsolete 4/01)  
 1981 = PTCA Catheters (eff. 1/01) (obsolete 4/01)  
 2000 = Orbiter ST Steerable Cath (eff. 1/01) (obsolete 4/01)  
 2001 = Constellation Diag Cath (eff. 1/01) (obsolete 4/01)



2002 = Irvine 5F Inquiry Diag EP Cath (eff. 1/01) (obsolete 4/01)  
 2003 = Irvine 6F Inquiry Diag EP Cath (eff. 1/01) (obsolete 4/01)  
 2004 = Biosense EP Cath -- Octapolar (eff. 1/01) (obsolete 4/01)  
 2005 = Biosense EP Cath -- Hexapolar (eff. 1/01) (obsolete 4/01)  
 2006 = Biosense EP Cath -- Decapolar (eff. 1/01) (obsolete 4/01)  
 2007 = Irvine 6F Luma-Cath EP Cath (eff. 1/01) (obsolete 4/01)  
 2008 = 7F Luma-Cath EP Cath 81910-15 (eff. 1/01) (obsolete 4/01)  
 2009 = Irvine 7F Luma-Cath EP Cath (eff. 1/01) (obsolete 4/01)  
 2010 = Fixed Curve EP Cath (eff. 1/01) (obsolete 4/01)  
 2011 = Deflectable Tip Cath--Quad (eff. 1/01) (obsolete 4/01)  
 2012 = Celsius Abln Cath (eff. 1/01) (obsolete 4/01)  
 2013 = Celsius Large Abln Cath (eff. 1/01) (obsolete 4/01)  
 2014 = Celsius II Asym Abln Cath (eff. 1/01) (obsolete 4/01)  
 2015 = Celsius II Sym Abln Cath (eff. 1/01) (obsolete 4/01)  
 2016 = Navi-Star DS, Navi-Star Ther (eff. 1/01) (obsolete 4/01)  
 2017 = Navi-Star Abln Cath (eff. 1/01) (obsolete 4/01)  
 2018 = Polaris T Ablation Cath (eff. 1/01) (obsolete 4/01)  
 2019 = EP Deflectable Cath (eff. 1/01) (obsolete 4/01)  
 2020 = Blazer II XP Abln Cath (eff. 1/01) (obsolete 4/01)  
 2021 = SilverFlex EP Cath (eff. 1/01) (obsolete 4/01)  
 2022 = CP Chilli Cooled Abln Cath (eff. 1/01) (obsolete 4/01)  
 2023 = Chilli Cld AblnCath-std, lg (eff. 1/01) (obsolete 4/01)  
 2100 = CP CS Reference Cath (eff. 1/01) (obsolete 4/01)  
 2102 = CP Radii 7F EP Cath (eff. 1/01) (obsolete 4/01)  
 2103 = CP Radii 7F EP Cath w/Track (eff. 1/01) (obsolete 4/01)  
 2104 = Lasso Deflectable Cath (eff. 1/01) (obsolete 4/01)  
 2151 = Veripath Guiding Cath (eff. 1/01) (obsolete 4/01)  
 2152 = Cordis Vista Brite Tip Cath (eff. 1/01) (obsolete 4/01)  
 2153 = Bard Viking Cath (eff. 1/01) (obsolete 4/01)  
 2200 = Arrow-Trerotola PTD Cath (eff. 1/01) (obsolete 4/01)  
 2300 = Varisource Stnd Catheters (eff. 1/01) (obsolete 4/01)  
 2597 = Clinicath/kit 16/18 sgl/dbl (eff. 1/01) (obsolete 4/01)  
 2598 = Clinicath 18/20/24-G single (eff. 1/01) (obsolete 4/01)  
 2599 = Clinicath 16/18-G-double (eff. 1/01) (obsolete 4/01)  
 2601 = Bard DL Ureteral Cath (eff. 1/01) (obsolete 4/01)  
 2602 = Vitesse Laser Cath 1.4/1.7mm (eff. 1/01) (obsolete 4/01)  
 2603 = Vitesse Laser Cath 2.0mm (eff. 1/01) (obsolete 4/01)  
 2604 = Vitesse E Laser Cath 2.0mm (eff. 1/01) (obsolete 4/01)  
 2605 = Extreme Laser Catheter (eff. 1/01) (obsolete 4/01)  
 2606 = SpineCath XL Catheter (eff. 1/01) (obsolete 4/01)  
 2607 = SpineCath Intradiscal Cath (eff. 1/01) (obsolete 4/01)  
 2608 = Scimed 6F Wiseguide Cath (eff. 1/01) (obsolete 4/01)  
 2609 = Flexima Bil Drainage Cath (eff. 1/01) (obsolete 4/01)  
 2610 = FlexTipPlus Intraspinal Cath (eff. 1/01) (obsolete 4/01)

2611 = AlgoLine Intraspinal Cath (eff. 1/01) (obsolete 4/01)  
 2612 = InDura Catheter (eff. 1/01) (obsolete 4/01)  
 2615 = Sealant, pulmonary, liquid (eff. 4/01)  
 2616 = Brachytx seed, Yttrium-90 (eff. 4/01)  
 2617 = Stent, non-cor, tem w/o del (eff. 4/01)  
 2618 = Probe, cryoablation (eff. 4/01)  
 2619 = Pmkr, dual, non rate-resp (eff. 4/01)  
 2620 = Pmkr, single, non rate-resp (eff. 4/01)  
 2621 = Pmkr, other than single/dual (eff. 4/01)  
 2622 = Prosthesis, penile, non-inf (eff. 4/01)  
 2625 = Stent, non-cor , tem w/del sys (eff. 4/01)  
 2626 = Infusion pump, non-prog, temp (eff. 4/01)  
 2627 = Cath, suprapubic/cystoscopic (eff. 4/01)  
 2628 = Catheter, occlusion (eff. 4/01)  
 2629 = Intro/sheath, laser (eff. 4/01)  
 2630 = Cath, EP, temp-controlled (eff. 4/01)  
 2631 = Rep dev, urinary, w/o sling (eff. 4/01)  
 2700 = MycroPhylax Plus CS defib (eff. 1/01) (obsolete 4/01)  
 2701 = Phylax XM SC defib (eff. 1/01) (obsolete 4/01)  
 2702 = Ventak Prizm 2VR Defib (eff. 1/01) (obsolete 4/01)  
 2703 = Ventak Prizm VR HE Defib (eff. 1/01) (obsolete 4/01)  
 2704 = Ventak Mini IV + Defib (eff. 1/01) (obsolete 4/01)  
 2801 = Defender IV DR 612 DC defib (eff. 1/01) (obsolete 4/01)  
 2802 = Phylax AV DC defib (eff. 1/01) (obsolete 4/01)  
 2803 = Ventak Prizm DR HE Defib (eff. 1/01) (obsolete 4/01)  
 2804 = Ventak Prizm 2 DR Defib (eff. 1/01) (obsolete 4/01)  
 2805 = Jewel AF 7250 Defib (eff. 1/01) (obsolete 4/01)  
 2806 = GEM VR 7227 Defib (eff. 1/01) (obsolete 4/01)  
 2807 = Contak CD 1823 (eff. 1/01) (obsolete 4/01)  
 2808 = Contak TR 1241 (eff. 1/01) (obsolete 4/01)  
 3001 = Kainox SL/RV defib lead (eff. 1/01) (obsolete 4/01)  
 3002 = EasyTrak Defib Lead (eff. 1/01) (obsolete 4/01)  
 3003 = Endotak SQ Array XP lead (eff. 1/01) (obsolete 4/01)  
 3004 = Intervene Defib lead (eff. 1/01) (obsolete 4/01)  
 3400 = Siltex Spectrum, Contour Prof (eff. 1/01) (obsolete 4/01)  
 3401 = Saline-Filled Spectrum (eff. 1/01) (obsolete 4/01)  
 3500 = Mentor alpha I Inf Penile Pros (eff. 1/01) (obsolete 4/01)  
 3510 = AMS 800 Urinary Pros (eff. 1/01) (obsolete 4/01)  
 3551 = Choice/PT Graphix/Luge/Trooper (eff. 1/01) (obsolete 4/01)  
 3552 = Hi-Torque Whisper (eff. 1/01) (obsolete 4/01)  
 3553 = Cordis guidewires (eff. 1/01) (obsolete 4/01)  
 3554 = Jindo guidewire (eff. 1/01) (obsolete 4/01)  
 3555 = Wholey Hi-Torque Plus GW (eff. 1/01) (obsolete 4/01)  
 3556 = Wave/FlowWire Guidewire (eff. 1/01) (obsolete 4/01)

3557 = HyTek guidewire (eff. 1/01) (obsolete 4/01)  
 3800 = SynchroMed EL infusion pump (eff. 1/01) (obsolete 4/01)  
 3801 = Arrow/Microject PCAQ Sys (eff. 1/01) (obsolete 4/01)  
 3851 = Elastic UV IOL AA-4203T/TF/TL (eff. 1/01) (obsolete 4/01)  
 4000 = Opus G 4621, 4624 SC pmkr (eff. 1/01) (obsolete 4/01)  
 4001 = Opus S 4121/4124 SC pmkr (eff. 1/01) (obsolete 4/01)  
 4002 = Talent 113 SC pmkr (eff. 1/01) (obsolete 4/01)  
 4003 = Kairos SR SC pmkr (eff. 1/01) (obsolete 4/01)  
 4004 = Actros SR, Actros SLR SC pmkr (eff. 1/01) (obsolete 4/01)  
 4005 = Philos SR/SR-B SC pmkr (eff. 1/01) (obsolete 4/01)  
 4006 = Pulsar Max II SR pmkr (eff. 1/01) (obsolete 4/01)  
 4007 = Marathon SR pmkr (eff. 1/01) (obsolete 4/01)  
 4008 = Discovery II SSI pmkr (eff. 1/01) (obsolete 4/01)  
 4009 = Discovery II SR pmkr (eff. 1/01) (obsolete 4/01)  
 4300 = Integrity AFx DR 5342 pmkr (eff. 1/01) (obsolete 4/01)  
 4301 = Integrity AFx DR 5346 pmkr (eff. 1/01) (obsolete 4/01)  
 4302 = Affinity VDR 5430 DR (eff. 1/01) (obsolete 4/01)  
 4303 = Brio 112 DC pmkr (eff. 1/01) (obsolete 4/01)  
 4304 = Brio 212, Talent 213/223 DC pmkr (eff. 1/01) (obsolete 4/01)  
 4305 = Brio 222 DC pmkr (eff. 1/01) (obsolete 4/01)  
 4306 = Brio 220 DC pmkr (eff. 1/01) (obsolete 4/01)  
 4307 = Kairos DR DC pmkr (eff. 1/01) (obsolete 4/01)  
 4308 = Inos2, Inos2+ DC pmkr (eff. 1/01) (obsolete 4/01)  
 4309 = Actros DR, D, DR-A, SLR DC pmkr (eff. 1/01) (obsolete 4/01)  
 4310 = Actros DR-B DC pmkr (eff. 1/01) (obsolete 4/01)  
 4311 = Philos DR/DR-B/SLR DC (eff. 1/01) (obsolete 4/01)  
 4312 = Pulsar Max II DR pmkr (eff. 1/01) (obsolete 4/01)  
 4313 = Marathon DR pmkr (eff. 1/01) (obsolete 4/01)  
 4314 = Momentum DR pmkr (eff. 1/01) (obsolete 4/01)  
 4315 = Selection AFm pmkr (eff. 1/01) (obsolete 4/01)  
 4316 = Discovery II DR (eff. 1/01) (obsolete 4/01)  
 4317 = Discovery II DDD (eff. 1/01) (obsolete 4/01)  
 4600 = Snynox, Polyrox, Eloxx, Retroxx (eff. 1/01) (obsolete 4/01)  
 4602 = Tendril SDX, 1488K pmkr lead (eff. 1/01) (obsolete 4/01)  
 4603 = Oscan/Flexion pmkr lead (eff. 1/01) (obsolete 4/01)  
 4604 = CrystallineActFix, CapsureFix (eff. 1/01) (obsolete 4/01)  
 4605 = CapSure Epi pmkr lead (eff. 1/01) (obsolete 4/01)  
 4606 = Flextend pmkr lead (eff. 1/01) (obsolete 4/01)  
 4607 = FinelineII/EZ, ThinlineII/EZ (eff. 1/01) (obsolete 4/01)  
 5000 = BX Velocity w/Hepacoat (eff. 1/01) (obsolete 4/01)  
 5001 = Memotherm Bil Stent, sm, med (eff. 1/01) (obsolete 4/01)  
 5002 = Memotherm Bil Stent, large (eff. 1/01) (obsolete 4/01)  
 5003 = Memotherm Bil Stent, x-large (eff. 1/01) (obsolete 4/01)  
 5004 = PalmazCorinthian IQ Bil Stent (eff. 1/01) (obsolete 4/01)

5005 = PalmazCorinthian IQ Trans/Bil (eff. 1/01) (obsolete 4/01)  
 5006 = PalmazTran Bil Stent Sys-Med (eff. 1/01) (obsolete 4/01)  
 5007 = PalmazTran XL Bil Stent--40mm (eff. 1/01) (obsolete 4/01)  
 5008 = PalmazTran XL Bil Stent--50mm (eff. 1/01) (obsolete 4/01)  
 5009 = VistaFlex Biliary Stent (eff. 1/01) (obsolete 4/01)  
 5010 = Rapid Exchange Bil Stent Sys (eff. 1/01) (obsolete 4/01)  
 5011 = IntraStent, IntraStent LP (eff. 1/01) (obsolete 4/01)  
 5012 = IntraStent DoubleStrut LD (eff. 1/01) (obsolete 4/01)  
 5013 = IntraStent DoubleStrut XS (eff. 1/01) (obsolete 4/01)  
 5014 = AVE Bridge Stent Sys-10/17/28 (eff. 1/01) (obsolete 4/01)  
 5015 = AVE/X3 Bridge Sys, 40-100 (eff. 1/01) (obsolete 4/01)  
 5016 = Biliary stent single use cov (eff. 1/01) (obsolete 4/01)  
 5017 = WallstentRP Bil--20/40/60/68mm (eff. 1/01) (obsolete 4/01)  
 5018 = WallstentRP Bil--80/94mm (eff. 1/01) (obsolete 4/01)  
 5019 = Flexima Bil Stent Sys (eff. 1/01) (obsolete 4/01)  
 5020 = Smart Nitinol Stent--20mm (eff. 1/01) (obsolete 4/01)  
 5021 = Smart Nitinol Stent--40/60mm (eff. 1/01) (obsolete 4/01)  
 5022 = Smart Nitinol Stent--80mm (eff. 1/01) (obsolete 4/01)  
 5023 = BX Velocity Stent--8/13mm (eff. 1/01) (obsolete 4/01)  
 5024 = BX Velocity Stent 18mm (eff. 1/01) (obsolete 4/01)  
 5025 = BX Velocity Stent 23 mm (eff. 1/01) (obsolete 4/01)  
 5026 = BX Velocity Stent 28/33mm (eff. 1/01) (obsolete 4/01)  
 5027 = BX Velocity Stent w/Hep--8/13mm (eff. 1/01) (obsolete 4/01)  
 5028 = BX Velocity Stent w/Hep--18mm (eff. 1/01) (obsolete 4/01)  
 5029 = BX Velocity Stent w/Hep--23mm (eff. 1/01) (obsolete 4/01)  
 5030 = Stent, coronary, S660 9/12mm (eff. 1/01) (obsolete 4/01)  
 5031 = Stent, coronary, S660 15/18mm (eff. 1/01) (obsolete 4/01)  
 5032 = Stent, coronary, S660 24/30mm (eff. 1/01) (obsolete 4/01)  
 5033 = Niroyal Stent Sys, 9mm (eff. 1/01) (obsolete 4/01)  
 5034 = Niroyal Stent Sys, 12/15mm (eff. 1/01) (obsolete 4/01)  
 5035 = Niroyal Stent Sys, 18mm (eff. 1/01) (obsolete 4/01)  
 5036 = Niroyal Stent Sys, 25mm (eff. 1/01) (obsolete 4/01)  
 5037 = Niroyal Stent Sys, 31mm (eff. 1/01) (obsolete 4/01)  
 5038 = BX Velocity Stent w/Raptor (eff. 1/01) (obsolete 4/01)  
 5039 = IntraCoil Periph Stent--40mm (eff. 1/01) (obsolete 4/01)  
 5040 = IntraCoil Periph Stent--60mm (eff. 1/01) (obsolete 4/01)  
 5041 = BeStent Over-the-Wire 24/30mm (eff. 1/01) (obsolete 4/01)  
 5042 = BeStent Over-the-Wire 18mm (eff. 1/01) (obsolete 4/01)  
 5043 = BeStent Over-the-Wire 15mm (eff. 1/01) (obsolete 4/01)  
 5044 = BeStent Over-the-Wire 9/12mm (eff. 1/01) (obsolete 4/01)  
 5045 = Multilink Tetra Cor Stent Sys (eff. 1/01) (obsolete 4/01)  
 5046 = Radius 20mm cor stent (eff. 1/01) (obsolete 4/01)  
 5047 = Niroyal Elite Cor Stent Sys (eff. 1/01) (obsolete 4/01)  
 5048 = GR II Coronary Stent (eff. 1/01) (obsolete 4/01)

5130 = Wilson-Cook Colonic Z-Stent (eff. 1/01) (obsolete 4/01)  
 5131 = Bard Colorectal Stent-60mm (eff. 1/01) (obsolete 4/01)  
 5132 = Bard Colorectal Stent-80mm (eff. 1/01) (obsolete 4/01)  
 5133 = Bard Colorectal Stent-100mm (eff. 1/01) (obsolete 4/01)  
 5134 = Enteral Wallstent-90mm (eff. 1/01) (obsolete 4/01)  
 5279 = Contour/Percuflex Stent (eff. 1/01) (obsolete 4/01)  
 5280 = Inlay Dbl Ureteral Stent (eff. 1/01) (obsolete 4/01)  
 5281 = Wallgraft Trach Sys 70mm (eff. 1/01) (obsolete 4/01)  
 5282 = Wallgraft Trach Sys 20/30/50 (eff. 1/01) (obsolete 4/01)  
 5283 = Wallstent/RP TIPS--80mm (eff. 1/01) (obsolete 4/01)  
 5284 = Wallstent TrachUltraFlex (eff. 1/01) (obsolete 4/01)  
 5600 = Closure dev, VasoSeal ES (eff. 1/01) (obsolete 4/01)  
 5601 = VasoSeal Model 1000 (eff. 1/01) (obsolete 4/01)  
 6001 = Composix Mesh 8/21 in (eff. 1/01) (obsolete 4/01)  
 6002 = Composix Mesh 32 in (eff. 1/01) (obsolete 4/01)  
 6003 = Composix Mesh 48 in (eff. 1/01) (obsolete 4/01)  
 6004 = Composix Mesh 80 in (eff. 1/01) (obsolete 4/01)  
 6005 = Composix Mesh 140 in (eff. 1/01) (obsolete 4/01)  
 6006 = Composix Mesh 144 in (eff. 1/01) (obsolete 4/01)  
 6012 = Pelvicol Collagen 8/14 sq cm (eff. 1/01) (obsolete 4/01)  
 6013 = Pelvicol Collagen 21/24/28 sq cm (eff. 1/01) (obsolete 4/01)  
 6014 = Pelvicol Collagen 36 sq cm (eff. 1/01) (obsolete 4/01)  
 6015 = Pelvicol Collagen 48 sq cm (eff. 1/01) (obsolete 4/01)  
 6016 = Pelvicol Collagen 96 sq cm (eff. 1/01) (obsolete 4/01)  
 6017 = Gore-Tex DualMesh 75/96 sq cm (eff. 1/01) (obsolete 4/01)  
 6018 = Gore-Tex DualMesh 150 sq cm (eff. 1/01) (obsolete 4/01)  
 6019 = Gore-Tex DualMesh 285 sq cm (eff. 1/01) (obsolete 4/01)  
 6020 = Gore-Tex DualMesh 432 sq cm (eff. 1/01) (obsolete 4/01)  
 6021 = Gore-Tex DualMesh 600 sq cm (eff. 1/01) (obsolete 4/01)  
 6022 = Gore-Tex DualMesh 884 sq cm (eff. 1/01) (obsolete 4/01)  
 6023 = Gore-TexPlus 1mm, 75/96 sq cm (eff. 1/01) (obsolete 4/01)  
 6024 = Gore-TexPlus 1mm, 150 sq cm (eff. 1/01) (obsolete 4/01)  
 6025 = Gore-TexPlus 1mm, 285 sq cm (eff. 1/01) (obsolete 4/01)  
 6026 = Gore-TexPlus 1mm, 432 sq cm (eff. 1/01) (obsolete 4/01)  
 6027 = Gore-TexPlus 1mm, 600 sq cm (eff. 1/01) (obsolete 4/01)  
 6028 = Gore-TexPlus 1mm, 884 sq cm (eff. 1/01) (obsolete 4/01)  
 6029 = Gore-TexPlus 2mm, 150 sq cm (eff. 1/01) (obsolete 4/01)  
 6030 = Gore-TexPlus 2mm, 285 sq cm (eff. 1/01) (obsolete 4/01)  
 6031 = Gore-TexPlus 2mm, 432 sq cm (eff. 1/01) (obsolete 4/01)  
 6032 = Gore-TexPlus 2mm, 600 sq cm (eff. 1/01) (obsolete 4/01)  
 6033 = Gore-TexPlus 2mm, 884 sq cm (eff. 1/01) (obsolete 4/01)  
 6034 = Bard ePTFE: 150 sq cm-2mm (obsolete 4/01)  
 6035 = Bard ePTFE: 150sqcm-1mm,75-2mm (eff. 1/01) (obsolete 4/01)  
 6036 = Bard ePTFE: 50/75sqcm-1,2mm (eff. 1/01) (obsolete 4/01)

6037 = Bard ePTFE: 300 sq cm-1,2mm (eff. 1/01) (obsolete 4/01)  
 6038 = Bard ePTFE: 600 sq cm-1mm (eff. 1/01) (obsolete 4/01)  
 6039 = Bard ePTFE: 884sq cm-1mm (eff. 1/01) (obsolete 4/01)  
 6040 = Bard ePTFE: 600sq cm-2mm (eff. 1/01) (obsolete 4/01)  
 6041 = Bard ePTFE: 884sq cm -2mm (eff. 1/01) (obsolete 4/01)  
 6050 = Female Sling Sys w/wo Matrl (eff. 1/01) (obsolete 4/01)  
 6051 = Stratasis Sling, 20/40 cm (eff. 1/01) (obsolete 4/01)  
 6052 = Stratasis Sling, 60 cm (eff. 1/01) (obsolete 4/01)  
 6053 = Surgisis Soft Graft (eff. 1/01) (obsolete 4/01)  
 6054 = Surgisis Enhanced Graft (eff. 1/01) (obsolete 4/01)  
 6055 = Surgisis Enhanced Tissue (eff. 1/01) (obsolete 4/01)  
 6056 = Surgisis Soft Tissue Graft (eff. 1/01) (obsolete 4/01)  
 6057 = Surgisis Hernia Graft (eff. 1/01) (obsolete 4/01)  
 6058 = SurgiPro Hernia Plug, med/lg (eff. 1/01) (obsolete 4/01)  
 6080 = Male Sling Sys w/wo Matrial (eff. 1/01) (obsolete 4/01)  
 6200 = Exxcel Soft ePTFE vas graft (ef. 1/01) (obsolete 4/01)  
 6201 = Impra Venaflo--10/20cm (eff. 1/01) (obsolete 4/01)  
 6202 = Impra Venaflo--30/40 cm (eff. 1/01) (obsolete 4/01)  
 6203 = Impra Venaflo--50 cm, vt45 (eff. 1/01) (obsolete 4/01)  
 6204 = Impra Venaflo--stepped (eff. 1/01) (obsolete 4/01)  
 6205 = Impra Carboflo--10cm (eff. 1/01) (obsolete 4/01)  
 6206 = Impra Carboflo--20 cm (eff. 1/01) (obsolete 4/01)  
 6207 = Impra Carboflo--30/35/40cm (eff. 1/01) (obsolete 4/01)  
 6208 = Impra Carboflo--40/50cm (eff. 1/01) (obsolete 4/01)  
 6209 = Impra Carboflo--ctrflex (eff. 1/01) (obsolete 4/01)  
 6210 = Exxcel ePTFE vas graft (eff. 1/01) (obsolete 4/01)  
 6300 = Vanguard III Endovas Graft (eff. 1/01) (obsolete 4/01)  
 6500 = Preface Guiding Sheath (eff. 1/01) (obsolete 4/01)  
 6501 = Soft Tip Sheaths (eff. 1/01) (obsolete 4/01)  
 6502 = Perry Exchange Dilator (eff. 1/01) (obsolete 4/01)  
 6525 = Spectranetics Laser Sheath (eff. 1/01) (obsolete 4/01)  
 6600 = Micro Litho Flex Probes (eff. 1/01) (obsolete 4/01)  
 6650 = Fast-Cath Guiding Introducer (eff. 1/01) (obsolete 4/01)  
 6651 = Seal-Away Guding Introducer (eff. 1/01) (obsolete 4/01)  
 6652 = Bard Excalibur Introducer (eff. 1/01) (obsolete 4/01)  
 6700 = Focal Seal-L (eff. 1/01) (obsolete 4/01)  
 7000 = Amifostine, 500 mg (eligible for pass-through payments)  
 7001 = Amphotericin B lipid complex, 50 mg, Inj (eligible for pass-through payments)  
 7002 = Clonidine, HCl, 1 MG (eligible for pass-through payments) (obsolete 1/01)  
 7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-through payments)  
 7004 = Immune globulin intravenous human 5g, inj (eligible for pass-through payments)  
 7005 = Gonadorelin hcl, 100 mcg (eligible for pass-through payments)  
 7007 = Milrinone lacetate, per 5 ml, inj (not subject to national coinsurance)

7010 = Morphine sulfate concentrate (preservative free) per 10 mg (eligible for pass-through payments)  
 7011 = Oprelevakin, inj, 5 mg (eligible for pass-through payments)  
 7012 = Pentamidine isethionate, 300 mg (eligible for pass-through payments) (obsolete 1/01)  
 7014 = Fentanyl citrate, inj, up to 2 ml (eligible for pass-through payments)  
 7015 = Busulfan, oral 2 mg (eligible for pass-through payments)  
 7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments)  
 7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments) (obsolete 1/01)  
 7022 = Elliotts B Solution, per ml (eligible for pass-through payments)  
 7023 = Treatment for bladder calculi, i.e. Renacidin per 500 ml (eligible for pass-through payments)  
 7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments)  
 7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments)  
 7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments)  
 7027 = Fomepizole, 1.5 G (eligible for pass-through payments)  
 7028 = Fosphenytoin, 50 mg (eligible for pass-through payments)  
 7029 = Glatiramer acetate, 25 mg (eligible for pass-through payments)  
 7030 = Hemin, 1 mg (eligible for pass-through payments)  
 7031 = Octreotide Acetate, 500 mcg (eligible for pass-through payments)  
 7032 = Sermorelin acetate, 0.5 mg (eligible for pass-through payments)  
 7033 = Somatrem, 5 mg (eligible for pass-through payments)  
 7034 = Somatropin, 1 mg (eligible for pass-through payments)  
 7035 = Teniposide, 50 mg (eligible for pass-through payments)  
 7036 = Urokinase, inj, IV, 250,000 I.U. (not subject to national coinsurance)  
 7037 = Urofollitropin, 75 I.U. (eligible for pass-through payments)  
 7038 = Muromonab-CD3, 5 mg (eligible for pass-through payments)  
 7039 = Pegademase bovine inj 25 I.U. (eligible for pass-through payments)  
 7040 = Pentastarch 10% inj, 100 ml (eligible for pass-through payments)  
 7041 = Tirofiban HCL, 0.5 mg (not subject to national coinsurance)  
 7042 = Capecitabine, oral 150 mg (eligible for pass-through payments)  
 7043 = Infliximab, 10 MG (eligible for pass-through payments)  
 7045 = Trimetrexate Glucuronate (eligible for pass-through payments)  
 7046 = Doxorubicin Hcl Liposome (eligible for pass-through payments)  
 7047 = Droperidol/fentanyl inj (eff. 1/01)  
 7048 = Alteplase, 1 mg (eff. 1/01)  
 7049 = Filgrastim 480 mcg injection (eff. 1/01)  
 7315 = Sodium hyaluronate, 20 mg (eff. 1/01)  
 8099 = Spectranetics Lead Lock Dev (eff. 1/01) (obsolete 4/01)  
 8100 = Adhesion barrier, ADCON-L (eff. 1/01) (obsolete 4/01)  
 8102 = SurgiVision Esoph Coil (eff. 1/01) (obsolete 4/01)  
 9000 = Na chromate Cr51, per 0.25mCi (eff. 1/01)  
 9001 = Linezolid inj, 200mg (eff. 1/01)

9002 = Tenecteplase, 50mg/vial (eff. 1/01)  
 9003 = Palivizumab, per 50 mg (eff. 1/01)  
 9004 = Gemtuzumab ozogamicin inj, 5mg (eff. 1/01)  
 9005 = Reteplase inj, half-kit, 18.8 mg/vial (eff. 1/01)  
 9006 = Tacrolimus inj, per 5 mg (1 amp) (eff. 1/01)  
 9007 = Baclofen Intrathecal kit-1amp (eff. 1/01)  
 9008 = Baclofen Refill Kit--500mcg (eff. 1/01)  
 9009 = Baclofen Refill Kit--2000mcg (eff. 1/01)  
 9010 = Baclofen Refill Kit--4000mcg (eff. 1/01)  
 9011 = Caffeine Citrate, inj, 1ml (eff. 1/01)  
 9012 = Arsenic Trioxide, 1mg/kg (eff. 4/01)  
 9013 = Co 57 Cobaltous Cl, 1 ml (eff. 4/01)  
 9100 = Iodinated I-131 Albumin (eff. 1/01)  
 9102 = 51 Na chromate, 50mCi (eff. 1/01)  
 9103 = Na lothalamate I-125, 10uCi (eff. 1/01)  
 9104 = Anti-thymocyte globin, 25 mg (eff. 1/01)  
 9105 = Hep B immun glob, per 1 ml (eff. 1/01)  
 9106 = Sirolimus 1 mg/ml (eff. 1/01)  
 9107 = Tinzaparin sodium, 2ml vial (eff. 1/01)  
 9108 = Thyrotropin Alfa, 1.1 mg (eff. 1/01)  
 9109 = Tirofiban hydrachloride 6.25 mg (eff. 1/01)  
 9217 = Leuprolide acetate for depot suspension, 7.5 mg (eff. 1/01)  
 9500 = Platelets, irradiated, ea unit (eff. 1/01)  
 9501 = Platelets, pheresis, ea unit (eff. 1/01)  
 9502 = Platelets, pher/irradiated, ea unit (eff. 1/01)  
 9503 = Fresh frozen plasma, ea unit (eff. 1/01)  
 9504 = RBC, deglycerolized, ea unit (eff. 1/01)  
 9505 = RBC, irradiated, ea unit (eff. 1/01)  
 9998 = Enoxaparin (eff. 1/01)

**COMMENT:** The APC field is populated for those claims that are required to process through Outpatient PPS Pricer.

The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

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## REV\_CNTR\_BENE\_PMT\_AMT

**LABEL:** Revenue Center Payment Amount to Beneficiary

**DESCRIPTION:** The amount paid to the beneficiary for the services reported on the line item.

**SHORT NAME:** RBENEPMT

**LONG NAME:** REV\_CNTR\_BENE\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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## REV\_CNTR\_BLOOD\_DDCTBL\_AMT

**LABEL:** Revenue Center Blood Deductible Amount

**DESCRIPTION:** This variable is the dollar amount the beneficiary is responsible for related to the deductible for blood products that appear on the revenue center record.

A deductible amount applies to the first 3 pints of blood (or equivalent units; applies only to whole blood or packed red cells - not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

**SHORT NAME:** REVBLOOD

**LONG NAME:** REV\_CNTR\_BLOOD\_DDCTBL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the blood deductible.

This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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## REV\_CNTR\_CASH\_DDCTBL\_AMT

**LABEL:** Revenue Center Cash Deductible Amount

**DESCRIPTION:** This variable is the beneficiary's liability under the annual Part B deductible for the revenue center record. The Part B deductible applies to both institutional (e.g., HOP) and non-institutional (e.g., Carrier and DME) services.

**SHORT NAME:** REVDCTBL

**LONG NAME:** REV\_CNTR\_CASH\_DDCTBL\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles.

This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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## REV\_CNTR\_COINSRNC\_WGE\_ADJSTD\_C

**LABEL:** Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount

**DESCRIPTION:** This variable is the beneficiary's liability for coinsurance for the revenue center record.

Beneficiaries only face coinsurance once they have satisfied Part B's annual deductible, which applies to both institutional (e.g., HOP) and non-institutional (e.g., Carrier and DME) services.

For most Part B services, coinsurance equals 20 percent of the allowed amount.

The coinsurance amount is wage adjusted, based on the metropolitan statistical area (MSA) where the provider is located.

**SHORT NAME:** WAGEADJ

**LONG NAME:** REV\_CNTR\_COINSRNC\_WGE\_ADJSTD\_C

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see the list of MLN publications at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

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.

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## REV\_CNTR\_DDCTBL\_COINSRNC\_CD

**LABEL:** Revenue Center Deductible Coinsurance Code

**DESCRIPTION:** Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

**SHORT NAME:** REVDEDCD

**LONG NAME:** REV\_CNTR\_DDCTBL\_COINSRNC\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 0 = Charges are subject to deductible and coinsurance
- 1 = Charges are not subject to deductible
- 2 = Charges are not subject to coinsurance
- 3 = Charges are not subject to deductible or coinsurance
- 4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:

- M = Override code; EGHP (employer group health plan) services involved
- N = Override code; non-EGHP services involved
- X = Override code: MSP (Medicare is secondary payer) cost avoided

**COMMENT:** -

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## REV\_CNTR\_DSCNT\_IND\_CD

**LABEL:** Revenue Center Discount Indicator Code

**DESCRIPTION:** This code represents a factor that specifies the amount of any Ambulatory payment classification (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.\*\***

**SHORT NAME:** DSCNTIND

**LONG NAME:** REV\_CNTR\_DSCNT\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** \*DISCOUNTING FORMULAS\*

1 = 1.0

2 =  $(1.0 + D(U-1))/U$

3 =  $T/U$

4 =  $(1+D)/U$

5 = D

6 =  $TD/U$

7 =  $D(1+D)/U$

8 =  $2.0/U$

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

**COMMENT:** This field is populated for those claims that are required to process through Outpatient prospective payment system (PPS or OPPOS) PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPOS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPOS/HHPPS). The

original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward.

Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

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## REV\_CNTR\_DT

**LABEL:** Revenue Center Date

**DESCRIPTION:** This is the date of service for the revenue center record.

However, it is populated only for home health claims, hospice claims, and Part B institutional (HOP) claims.

For home health claims, which are paid based on episodes that can last up to 60 days, this variable indicates the dates for the individual visits.

**SHORT NAME:** REV\_DT

**LONG NAME:** REV\_CNTR\_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## REV\_CNTR\_IDE\_NDC\_UPC\_NUM

**LABEL:** Revenue Center IDE, NDC, or UPC Number

**DESCRIPTION:** This field may contain one of three types of identifiers: the National Drug Code (NDC), the Universal Product Code (UPC), or the number assigned by the Food and Drug Administration (FDA) to an investigational device (IDE) after the manufacturer has approval to conduct a clinical trial.

The IDEs will have a revenue center code '0624'.

**SHORT NAME:** IDENDC

**LONG NAME:** REV\_CNTR\_IDE\_NDC\_UPC\_NUM

**TYPE:** CHAR

**LENGTH:** 24

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** 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)).

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## REV\_CNTR\_NCVRD\_CHRG\_AMT

**LABEL:** Revenue Center Non-Covered Charge Amount

**DESCRIPTION:** The charge amount related to a revenue center code for services that are not covered by Medicare.

**SHORT NAME:** REV\_NCVR

**LONG NAME:** REV\_CNTR\_NCVRD\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** -

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## REV\_CNTR\_NDC\_QTY

**LABEL:** Revenue Center National Drug Code (NDC) Quantity

**DESCRIPTION:** Effective with Version 'J', the quantity dispensed for the drug reflected on the revenue center line item.

**SHORT NAME:** REV\_CNTR\_NDC\_QTY

**LONG NAME:** REV\_CNTR\_NDC\_QTY

**TYPE:** NUM

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** The unit of measurement for the drug that was administered (e.g., grams, liters) is indicated in the variable called REV\_CNTR\_NDC\_QTY\_QLFR\_CD.

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## REV\_CNTR\_NDC\_QTY\_QLFR\_CD

**LABEL:** Revenue Center NDC Quantity Qualifier Code

**DESCRIPTION:** Effective with Version 'J', the code used to indicate the unit of measurement for the drug that was administered.

**SHORT NAME:** REV\_CNTR\_NDC\_QTY\_QLFR\_CD

**LONG NAME:** REV\_CNTR\_NDC\_QTY\_QLFR\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:** F2 = International Unit  
GR = Gram  
ML = Milliliter  
UN = Unit

**COMMENT:** The quantity of the drug dispensed is indicated in the variable called REV\_CNTR\_NDC\_QTY.

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## REV\_CNTR\_OTAF\_PMT\_CD

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Revenue Center Obligation to Accept As Full (OTAF) Payment Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>DESCRIPTION:</b> | The code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>SHORT NAME:</b>  | OTAF_1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>LONG NAME:</b>   | REV_CNTR_OTAF_PMT_CD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>LENGTH:</b>      | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>VALUES:</b>      | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>COMMENT:</b>     | <p>This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPTS rules so those lines would not have data in this field.</p> <p>Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.</p> |

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## REV\_CNTR\_PACKG\_IND\_CD

**LABEL:** Revenue Center Packaging Indicator Code

**DESCRIPTION:** The code used to identify those services that are packaged/bundled with another service.

**SHORT NAME:** PACKGIND

**LONG NAME:** REV\_CNTR\_PACKG\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 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
- 3 = Artificial charges for surgical procedure (eff. 7/2004)

**COMMENT:** NOTE1: This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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## REV\_CNTR\_PMT\_AMT\_AMT

**LABEL:** Revenue Center (Medicare) Payment Amount

**DESCRIPTION:** To obtain the Medicare payment amount for the services reported on the revenue center record, it is more accurate to use a different variable called the revenue center Medicare provider payment amount (REV\_CNTR\_PRVDR\_PMT\_AMT).

For Home Health, use the claim-level Medicare payment amount (variable that is the total of all revenue center records on the claim, which is called CLM\_PMT\_AMT), since each visit is not paid separately.

**SHORT NAME:** REVPMT

**LONG NAME:** REV\_CNTR\_PMT\_AMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPSS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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## REV\_CNTR\_PMT\_MTHD\_IND\_CD

**LABEL:** Revenue Center Payment Method Indicator Code

**DESCRIPTION:** 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 status indicator and the 2nd position being the payment indicator.

**SHORT NAME:** PMTMTHD

**LONG NAME:** REV\_CNTR\_PMT\_MTHD\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 0 = Unknown Value (but present in data)
- 1 = Paid standard hospital OPPS amount (status indicators K, S,T,V,X)
- 2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes)
- 3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z)
- 4 = Paid at reasonable cost (status indicator F,L)
- 5 = Additional payment for drug or biological (status indicator G)
- 6 = Additional payment for device (status indicator H)
- 7 = Additional payment for new drug or new biological (status indicator J)
- 8 = Paid partial hospitalization per diem (status indicator P)
- 9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services))

\*\*\*\*\*VALUES PRIOR TO 10/3/2005\*\*\*\*\*

\*\*\*\*\*Service Status Indicator\*\*\*\*\*

\*\*\*\*\* 1st position \*\*\*\*\*

- A = Services not paid under OPPS
- C = Inpatient procedure
- E = Non-covered items or services
- F = Corneal tissue acquisition
- G = Current drug or biological pass-through
- H = Device pass-through
- J = New drug or new biological pass-through
- N = Packaged incidental service
- P = Partial hospitalization services



S = Significant procedure not subject to multiple procedure discounting  
T = Significant procedure subject to multiple procedure discounting  
V = Medical visit to clinic or emergency department  
X = Ancillary service

\*\*\*\*\*Payment Indicator\*\*\*\*\*

\*\*\*\*\* 2nd position \*\*\*\*\*

1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)  
2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)  
3 = Not paid (service indicators C & E)  
4 = Acquisition cost paid (service indicator F)  
5 = Additional payment for current drug or biological (service indicator G)  
6 = Additional payment for device (service indicator H)  
7 = Additional payment for new drug or new biological (service indicator J)  
8 = Paid partial hospitalization per diem (service indicator P)  
9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training))

**COMMENT:** Prior to 10/2005, this variable contained the valid values for both the payment indicator and status indicator. Effective 10/2005, only the payment indicator codes remain in this table and the status indicator is housed in a new field named: REV\_CNTR\_STUS\_IND\_CD (with the corresponding values in the new table: REV\_CNTR\_STUS\_IND\_TB). Both the payment indicator and status indicator values have been expanded to 2-bytes.

This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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## REV\_CNTR\_PRCNG\_IND\_CD

**LABEL:** Revenue Center Pricing Indicator Code

**DESCRIPTION:** The code used to identify if there was a deviation from the standard method of calculating payment amount.

**SHORT NAME:** REV\_CNTR\_PRCNG\_IND\_CD

**LONG NAME:** REV\_CNTR\_PRCNG\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.
- B = A valid HCPCS code subject to the fee schedule payment. for the provider billed charges. NOTE: There is an exception for Critical Access Hospitals (provider numbers XX1300-XX1399) with reimbursement method 'J' (all-inclusive method) and dates of service on or after 7/1/01. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.
- C = Unlisted Rehabilitation Carrier Priced HCPCS
- D = A valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.
- E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.
- F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS. NOTE: The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for Inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.
- G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.
- H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule,

provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category of DME.

- I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.
- J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.
- K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.
- L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review. This code will be automatically set by the system.
- M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months. This must be set by Medical Review. This must be set by Medical Review when approved for payment.
- N = Paid based on the fee amount for non ESRD TOB's. NOTE: Fee amount is paid regardless of charges.
- Q = Manual pricing
- R = A valid radiology HCPCS code and is subject to APC. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges.
- S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate.
- T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.
- U = Valid ambulance HCPCS. A fee amount is present. The amount payable is a blended amount based on a percentage of the fee schedule and a percentage of the reasonable cost. The fee amount is subject to coinsurance and deductible.
- X = Unclassified drug as subject to manual pricing.

**COMMENT:** This field is populated for those claims that are required to process through the Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X,13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code

'07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

VALUES D, U & T REPRESENT THE FOLLOWING:

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

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## REV\_CNTR\_PRVDR\_PMT\_AMT

**LABEL:** Revenue Center (Medicare) Provider Payment Amount

**DESCRIPTION:** The amount Medicare paid for the services reported on the revenue center record.

This field is rarely populated for Part A claims due to per-diem or DRG payments; the claim payment amounts should be used instead.

For Hospital Outpatient services (also called Institutional Outpatient claims, which consist of claim type [variable called NCH\_CLM\_TYPE\_CD]= 40), this variable can be summed across all revenue center lines for the claim to obtain the total Medicare claim payment amount.

**SHORT NAME:** RPRVDPMT

**LONG NAME:** REV\_CNTR\_PRVDR\_PMT\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

Additional information regarding claim versus revenue-line level payments can be found in a CCW Technical Guidance document entitled: "Getting Started with Medicare Administrative Data."

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## REV\_CNTR\_PTNT\_RSPNSBLTY\_PMT

**LABEL:** Revenue Center Patient Responsibility Payment Amount

**DESCRIPTION:** The amount paid by the beneficiary to the provider for the line item service.

**SHORT NAME:** PTNTRESP

**LONG NAME:** REV\_CNTR\_PTNT\_RSPNSBLTY\_PMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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## REV\_CNTR\_RATE\_AMT

**LABEL:** Revenue Center Rate Amount

**DESCRIPTION:** Charges relating to unit cost associated with the revenue center code.

**SHORT NAME:** REV\_RATE

**LONG NAME:** REV\_CNTR\_RATE\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** For SNF PPS claims (when revenue center code equals '0022'), CMS 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).

For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

Under HH PPS (when revenue center code equals '0023'), CMS 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.

For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

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.

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## REV\_CNTR\_RDCD\_COINSRNC\_AMT

**LABEL:** Revenue Center Reduced Coinsurance Amount

**DESCRIPTION:** For all services subject to Outpatient prospective payment system (PPS or OPPS), the amount of coinsurance applicable to the line for a particular service (as indicated by the HCPCS code) for which the provider has elected to reduce the coinsurance amount.

**SHORT NAME:** RDCDCOIN

**LONG NAME:** REV\_CNTR\_RDCD\_COINSRNC\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS.

These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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

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## REV\_CNTR\_STUS\_IND\_CD

**LABEL:** Revenue Center Status Indicator Code

**DESCRIPTION:** This variable indicates how the service listed on the revenue center record was priced for payment purposes.

The revenue center status indicator code is most useful with outpatient hospital claims, where multiple methods may be used to determine the payment amount for the various revenue center records on the claim (for example, some lines may be bundled into an APC and paid under the outpatient PPS, while other lines may be paid under other fee schedules).

**SHORT NAME:** REVSTIND

**LONG NAME:** REV\_CNTR\_STUS\_IND\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- A = Services not paid under OPPS; uses a different fee schedule (e.g., ambulance, PT, mammography)
- B = Non-allowed item or service for OPPS; may be paid under a different bill type (e.g., CORF)
- C = Inpatient procedure (not paid under OPPS)
- E = Non-allowed item or service (not paid by OPPS or any other Medicare payment system)
- F = Corneal tissue acquisition, certain CRNA services and Hepatitis B vaccinations
- G = Drug/biological pass-through (separate APC includes this pass-through amount)
- H = Device pass-through (separate cost-based pass-through payment, not subject to coinsurance)
- J = New drug or new biological pass-through
- J1 = Primary service and all adjunctive services on the claim (comprehensive APC; effective 01/2015)
- K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources (paid under OPPS; separate APC payment)
- L = Flu/PPV vaccines
- M = Service not billable to fiscal intermediary [now a MAC] (not paid under OPPS)
- N = Packaged incidental service (no separate APC payment)
- P = Paid partial hospitalization per diem APC payment
- Q1 = Separate payment made; OPPS - APC (effective 2009)
- Q2 = No separate payment made; OPPS - APC were packaged into payment for other services (effective 2009)

- Q3 = May be paid through a composite APC-based on composite-specific criteria or separately through single code APCs when the criteria are not met (effective 2009)
- R = Blood products
- S = Significant procedure not subject to multiple procedure discounting
- T = Significant procedure subject to multiple procedure discounting
- U = Brachytherapy
- V = Medical visit to clinic or emergency department
- W = Invalid HCPCS or invalid revenue code with blank HCPCS
- X = Ancillary service
- Y = Non-implantable DME(e.g., therapeutic shoes; not paid under OPPS -bill to DMERC)
- Z = Valid revenue with blank HCPCS and no other SI assigned

**COMMENT:** This 2-byte indicator was added 10/2005 due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

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## REV\_CNTR\_TOT\_CHRG\_AMT

**LABEL:** Revenue Center Total Charge Amount

**DESCRIPTION:** 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.

**SHORT NAME:** REV\_CHRG

**LONG NAME:** REV\_CNTR\_TOT\_CHRG\_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** 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 Inpatient Rehabilitation Facility (IRF) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units.
- (6) 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).

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## REV\_CNTR\_UNIT\_CNT

**LABEL:** Revenue Center Unit Count

**DESCRIPTION:** 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.

**SHORT NAME:** REV\_UNIT

**LONG NAME:** REV\_CNTR\_UNIT\_CNT

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** 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.

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## RFR\_PHYSN\_NPI

**LABEL:** Claim Referring Physician NPI Number

**DESCRIPTION:** The national provider identifier (NPI) number assigned to uniquely identify the referring physician.

**SHORT NAME:** RFR\_PHYSN\_NPI\*

**LONG NAME:** RFR\_PHYSN\_NPI

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** \* The short SAS name is RFR\_NPI in the Carrier and DME files

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

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## RFR\_PHYSN\_SPCLTY\_CD

**LABEL:** Claim Referring Physician NPI Number

**DESCRIPTION:** The code used to identify the CMS specialty code of the referring physician/practitioner.

**SHORT NAME:** RFR\_PHYSN\_SPCLTY\_CD

**LONG NAME:** RFR\_PHYSN\_SPCLTY\_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/03)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech / language pathology
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = General Psychiatry
- 28 = Colorectal surgery (formerly proctology)
- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation

- 32 = Anesthesiologist Assistants (eff. 4/1/03--previously grouped with Certified Registered Nurse Anesthetists (CRNA))
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometrist
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/03)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
- 47 = Independent Diagnostic Testing Facility (IDTF)
- 48 = Podiatry
- 49 = Ambulatory surgical center (formerly miscellaneous)
- 50 = Nurse practitioner
- 51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
- 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
- 54 = Medical supply company for DMERC (and not included in 51-53)
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-orthotist
- 58 = Medical supply company with registered pharmacist
- 59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
- 60 = Public health or welfare agencies (federal, state, and local)
- 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
- 62 = Psychologist (billing independently)
- 63 = Portable X-ray supplier
- 64 = Audiologist (billing independently)
- 65 = Physical therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 66 = Rheumatology

- 67 = Occupational therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
- 68 = Clinical psychologist
- 69 = Clinical laboratory (billing independently)
- 70 = Multispecialty clinic or group practice
- 71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
- 72 = Pain Management (eff. 1/1/02)
- 73 = Mass Immunization Roster Biller
- 74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
- 75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs -- eff. 4/1/03)
- 76 = Peripheral vascular disease
- 77 = Vascular surgery
- 78 = Cardiac surgery
- 79 = Addiction medicine
- 80 = Licensed clinical social worker
- 81 = Critical care (intensivists)
- 82 = Hematology
- 83 = Hematology/oncology
- 84 = Preventive medicine
- 85 = Maxillofacial surgery
- 86 = Neuropsychiatry
- 87 = All other suppliers (e.g. drug and department stores)
- 88 = Unknown supplier/provider specialty
- 89 = Certified clinical nurse specialist
- 90 = Medical oncology
- 91 = Surgical oncology
- 92 = Radiation oncology
- 93 = Emergency medicine
- 94 = Interventional radiology
- 95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory
- 96 = Optician
- 97 = Physician assistant
- 98 = Gynecologist/oncologist
- 99 = Unknown physician specialty
- A0 = Hospital (DMERCs only)
- A1 = SNF (DMERCs only)
- A2 = Intermediate care nursing facility (DMERCs only)
- A3 = Nursing facility, other (DMERCs only)
- A4 = Home Health Agency (DMERCs only)
- A5 = Pharmacy (DMERC)
- A6 = Medical supply company with respiratory therapist (DMERCs only)



A7 = Department store (DMERC)  
A8 = Grocery store (DMERC)  
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities, eff. 1/2005)  
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)  
B2 = Pedorthic Personnel (eff. 10/2/07)  
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/07)  
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/07)  
B5 = Ocularist  
C0 = Sleep medicine  
C1 = Centralized flu  
C2 = Indirect payment procedure  
C3 = Interventional cardiology  
C5 = Dentist (eff. 7/2016)

**COMMENT:** -

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## RFR\_PHYSN\_UPIN

**LABEL:** Carrier/DMERC Claim Ordering Physician UPIN Number

**DESCRIPTION:** The unique physician identification number (UPIN) of the physician who referred the beneficiary or the physician who ordered the Part B services or durable medical equipment (DME).

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** RFR\_UPIN

**LONG NAME:** RFR\_PHYSN\_UPIN

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## RLTCNDSQ

**LABEL:** Claim Related Condition Code Sequence

**DESCRIPTION:** The sequence number of the claim related condition code (variable called CLM\_RLT\_COND\_CD).

**SHORT NAME:** RLTCNDSQ

**LONG NAME:** RLT\_COND\_CD\_SEQ

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** -

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## RLT\_OCRNC\_CD\_SEQ

**LABEL:** Claim Related Occurrence Code Sequence

**DESCRIPTION:** The sequence number of the claim related occurrence code (variable called CLM\_RLT\_OCRNC\_CD).

**SHORT NAME:** RLTOCRSQ

**LONG NAME:** RLT\_OCRNC\_CD\_SEQ

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** -

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## RLT\_SPAN\_CD\_SEQ

**LABEL:** Claim Related Span Code Sequence

**DESCRIPTION:** The sequence number of the related span code (variable called CLM\_SPAN\_CD).

**SHORT NAME:** RLTSPNSQ

**LONG NAME:** RLT\_SPAN\_CD\_SEQ

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** -

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## RLT\_VAL\_CD\_SEQ

**LABEL:** Claim Related Value Code Sequence

**DESCRIPTION:** The sequence number of the related claim value code (variable called CLM\_VAL\_CD).

**SHORT NAME:** RLTVALSQ

**LONG NAME:** RLT\_VAL\_CD\_SEQ

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** CCW

**VALUES:** -

**COMMENT:** -

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## RNDRNG\_PHYSN\_NPI

**LABEL:** Rendering Physician NPI

**DESCRIPTION:** This variable is the National Provider Identifier (NPI) for the physician who rendered the services.

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** RNDRNG\_PHYSN\_NPI

**LONG NAME:** RNDRNG\_PHYSN\_NPI

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** This field appears on both the revenue center and base claim files.

CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no new UPINs (legacy numbers) will be generated for new physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

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## RNDRNG\_PHYSN\_SPCLTY\_CD

|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LABEL:</b>       | Claim or Revenue Center Rendering Physician Specialty Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>DESCRIPTION:</b> | The code used to identify the CMS specialty code of the rendering physician/practitioner.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>SHORT NAME:</b>  | RNDRNG_PHYSN_SPCLTY_CD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>LONG NAME:</b>   | RNDRNG_PHYSN_SPCLTY_CD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>TYPE:</b>        | CHAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>LENGTH:</b>      | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>SOURCE:</b>      | NCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>VALUES:</b>      | <ul style="list-style-type: none"><li>00 = Carrier wide</li><li>01 = General practice</li><li>02 = General surgery</li><li>03 = Allergy/immunology</li><li>04 = Otolaryngology</li><li>05 = Anesthesiology</li><li>06 = Cardiology</li><li>07 = Dermatology</li><li>08 = Family practice</li><li>09 = Interventional Pain Management (IPM) (eff. 4/1/03)</li><li>10 = Gastroenterology</li><li>11 = Internal medicine</li><li>12 = Osteopathic manipulative therapy</li><li>13 = Neurology</li><li>14 = Neurosurgery</li><li>15 = Speech / language pathology</li><li>16 = Obstetrics/gynecology</li><li>17 = Hospice and Palliative Care</li><li>18 = Ophthalmology</li><li>19 = Oral surgery (dentists only)</li><li>20 = Orthopedic surgery</li><li>21 = Cardiac Electrophysiology</li><li>22 = Pathology</li><li>24 = Plastic and reconstructive surgery</li><li>25 = Physical medicine and rehabilitation</li><li>26 = Psychiatry</li><li>27 = General Psychiatry</li><li>28 = Colorectal surgery (formerly proctology)</li><li>29 = Pulmonary disease</li><li>30 = Diagnostic radiology</li><li>31 = Intensive cardiac rehabilitation</li></ul> |



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- 52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
- 53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
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- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-orthotist
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- 80 = Licensed clinical social worker
- 81 = Critical care (intensivists)
- 82 = Hematology
- 83 = Hematology/oncology
- 84 = Preventive medicine
- 85 = Maxillofacial surgery
- 86 = Neuropsychiatry
- 87 = All other suppliers (e.g. drug and department stores)
- 88 = Unknown supplier/provider specialty
- 89 = Certified clinical nurse specialist
- 90 = Medical oncology
- 91 = Surgical oncology
- 92 = Radiation oncology
- 93 = Emergency medicine
- 94 = Interventional radiology
- 95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory
- 96 = Optician
- 97 = Physician assistant
- 98 = Gynecologist/oncologist
- 99 = Unknown physician specialty
- A0 = Hospital (DMERCs only)
- A1 = SNF (DMERCs only)
- A2 = Intermediate care nursing facility (DMERCs only)
- A3 = Nursing facility, other (DMERCs only)
- A4 = Home Health Agency (DMERCs only)
- A5 = Pharmacy (DMERC)
- A6 = Medical supply company with respiratory therapist (DMERCs only)

- A7 = Department store (DMERC)
- A8 = Grocery store (DMERC)
- A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities, eff. 1/2005)
- B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)
- B2 = Pedorthic Personnel (eff. 10/2/07)
- B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/07)
- B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/07)
- B5 = Ocularist
- C0 = Sleep medicine
- C1 = Centralized flu
- C2 = Indirect payment procedure
- C3 = Interventional cardiology
- C5 = Dentist (eff. 7/2016)

**COMMENT:** This field appears on both the revenue center and base claim files.

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## RNDRNG\_PHYSN\_UPIN

**LABEL:** Revenue Center Rendering Physician UPIN

**DESCRIPTION:** This variable is the unique physician identification number (UPIN) for the physician who rendered the services on the revenue center record.

NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

**SHORT NAME:** RNDRNG\_PHYSN\_UPIN

**LONG NAME:** RNDRNG\_PHYSN\_UPIN

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## RSN\_VISIT\_CD1

**LABEL:** Reason for Visit Diagnosis Code I

**DESCRIPTION:** The 1<sup>st</sup> diagnosis code used to identify the patient's reason for the Hospital Outpatient visit.

**SHORT NAME:** RSN\_VISIT\_CD1

**LONG NAME:** RSN\_VISIT\_CD1

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Prior to Version 'J', this field was: CLM\_ADMTG\_DGNS\_CD.

With Version 'J', the name has changed and there can be up to 3 occurrences of this group.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## RSN\_VISIT\_CD2

**LABEL:** Reason for Visit Diagnosis Code II

**DESCRIPTION:** The 2<sup>nd</sup> diagnosis code used to identify the patient's reason for the Hospital Outpatient visit.

**SHORT NAME:** RSN\_VISIT\_CD2

**LONG NAME:** RSN\_VISIT\_CD2

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Prior to Version 'J', this field was: CLM\_ADMTG\_DGNS\_CD.

With Version 'J', the name has changed and there can be up to 3 occurrences of this group.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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### RSN\_VISIT\_CD3

**LABEL:** Reason for Visit Diagnosis Code III

**DESCRIPTION:** The 3<sup>rd</sup> diagnosis code used to identify the patient's reason for the Hospital Outpatient visit.

**SHORT NAME:** RSN\_VISIT\_CD3

**LONG NAME:** RSN\_VISIT\_CD3

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Prior to Version 'J', this field was: CLM\_ADMTG\_DGNS\_CD.

With Version 'J', the name has changed and there can be up to 3 occurrences of this group.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## RSN\_VISIT\_VRSN\_CD1

**LABEL:** Reason for Visit Diagnosis Code I Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the 1<sup>st</sup> reason for visit diagnosis code is ICD-9 or ICD-10.

**SHORT NAME:** RSN\_VISIT\_VRSN\_CD1

**LONG NAME:** RSN\_VISIT\_VRSN\_CD1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

|       |   |        |
|-------|---|--------|
| Blank | = | ICD-9  |
| 9     | = | ICD-9  |
| 0     | = | ICD-10 |

**COMMENT:** With 5010, the diagnosis and procedure codes expanded to accommodate ICD-10.

On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## RSN\_VISIT\_VRSN\_CD2

**LABEL:** Reason for Visit Diagnosis Code II Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the 2<sup>nd</sup> reason for visit diagnosis code is ICD-9 or ICD-10.

**SHORT NAME:** RSN\_VISIT\_VRSN\_CD2

**LONG NAME:** RSN\_VISIT\_VRSN\_CD2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9  
9 = ICD-9  
0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes expanded to accommodate ICD-10.  
  
On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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### RSN\_VISIT\_VRSN\_CD3

**LABEL:** Reason for Visit Diagnosis Code III Diagnosis Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the 3<sup>rd</sup> reason for visit diagnosis code is ICD-9 or ICD-10.

**SHORT NAME:** RSN\_VISIT\_VRSN\_CD3

**LONG NAME:** RSN\_VISIT\_VRSN\_CD3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** Blank = ICD-9  
9 = ICD-9  
0 = ICD-10

**COMMENT:** With 5010, the diagnosis and procedure codes expanded to accommodate ICD-10.  
  
On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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## SRVC\_LOC\_NPI\_NUM

**LABEL:** Claim Service Location NPI Number

**DESCRIPTION:** The National Provider Identifier (NPI) of the location where the services were provided.

**SHORT NAME:** SRVC\_LOC\_NPI\_NUM

**LONG NAME:** SRVC\_LOC\_NPI\_NUM

**TYPE:** CHAR

**LENGTH:** 22

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** This field was new in January 2014. It is null/missing for all years prior.

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## SUPLRNUM

**LABEL:** DMERC Line Supplier Provider Number

**DESCRIPTION:** The billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.

**SHORT NAME:** SUPLRNUM

**LONG NAME:** PRVDR\_NUM

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** Different types of identifiers may be used. Refer to the variable called DMERC\_LINE\_SUPPLR\_TYPE\_CD to determine the type used for each line.

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## TAX\_NUM

**LABEL:** Line Provider Tax Number

**DESCRIPTION:** The federal taxpayer identification number (TIN) that identifies the physician/practice/supplier to whom payment is made for the line item service.

This number may be an employer identification number (EIN) or social security number (SSN).

**SHORT NAME:** TAX\_NUM

**LONG NAME:** TAX\_NUM

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** -

**COMMENT:** -

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## THRPY\_CAP\_IND\_CD1

**LABEL:** Therapy Cap Indicator 1 Code

**DESCRIPTION:** The field used to identify whether the claim line (or revenue center) is subject to a therapy cap.

**SHORT NAME:** THRPY\_CAP\_IND\_CD1

**LONG NAME:** THRPY\_CAP\_IND\_CD1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator is used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The \$3,700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

**COMMENT:** This field appears on the revenue center/ line files.

In the Carrier line file, there are up to five indicators for the therapy cap - see variables called THRPY\_CAP\_IND\_CD1 - THRPY\_CAP\_IND\_CD5. In institutional revenue center files (inpatient, SNF, hospice, home health, and outpatient), there are two occurrences of this field (THRPY\_CAP\_IND\_CD1 - THRPY\_CAP\_IND\_CD2).

Details regarding the therapy cap can be found on the CMS website, under the Medicare therapy services web page (see, for example: <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>).

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## THRPY\_CAP\_IND\_CD2

**LABEL:** Therapy Cap Indicator 2 Code

**DESCRIPTION:** The field used to identify whether the claim line (or revenue center) is subject to a therapy cap.

**SHORT NAME:** THRPY\_CAP\_IND\_CD2

**LONG NAME:** THRPY\_CAP\_IND\_CD2

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator is used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The \$3,700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

**COMMENT:** This field appears on the revenue center/ line files.

In the Carrier line file, There are up to five indicators for the therapy cap - see variables called THRPY\_CAP\_IND\_CD1 - THRPY\_CAP\_IND\_CD5. In institutional revenue center files (inpatient, SNF, hospice, home health, and outpatient), there are two occurrences of this field (THRPY\_CAP\_IND\_CD1 - THRPY\_CAP\_IND\_CD2).

Details regarding the therapy cap can be found on the CMS website, under the Medicare therapy services web page (see, for example: <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>).

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### THRPY\_CAP\_IND\_CD3

**LABEL:** Therapy Cap Indicator 3 Code

**DESCRIPTION:** The field used to identify whether the claim line is subject to a therapy cap.

**SHORT NAME:** THRPY\_CAP\_IND\_CD3

**LONG NAME:** THRPY\_CAP\_IND\_CD3

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator is used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The \$3,700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

**COMMENT:** In the Carrier line file, there are up to five indicators for the therapy cap - see variables called THRPY\_CAP\_IND\_CD1 - THRPY\_CAP\_IND\_CD5.

Details regarding the therapy cap can be found on the CMS website, under the Medicare therapy services web page (see, for example:

<https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>).

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## THRPY\_CAP\_IND\_CD4

**LABEL:** Therapy Cap Indicator 4 Code

**DESCRIPTION:** The field used to identify whether the claim line is subject to a therapy cap.

**SHORT NAME:** THRPY\_CAP\_IND\_CD4

**LONG NAME:** THRPY\_CAP\_IND\_CD4

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator is used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The \$3,700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

**COMMENT:** In the Carrier line file, there are up to five indicators for the therapy cap - see variables called THRPY\_CAP\_IND\_CD1 - THRPY\_CAP\_IND\_CD5.

Details regarding the therapy cap can be found on the CMS website, under the Medicare therapy services web page (see, for example:

<https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>).

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## THRPY\_CAP\_IND\_CD5

**LABEL:** Therapy Cap Indicator 5 Code

**DESCRIPTION:** The field used to identify whether the claim line is subject to a therapy cap.

**SHORT NAME:** THRPY\_CAP\_IND\_CD5

**LONG NAME:** THRPY\_CAP\_IND\_CD5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator is used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The \$3,700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

**COMMENT:** In the Carrier line file, there are up to five indicators for the therapy cap - see variables called THRPY\_CAP\_IND\_CD1 - THRPY\_CAP\_IND\_CD5.

Details regarding the therapy cap can be found on the CMS website, under the Medicare therapy services web page (see, for example:

<https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>).

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