Chronic Condition Data Warehouse

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CODEBOOK

Encounter Records

April 2018

Version 1.0

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Revision History

Revision Date	Version Number	Description	Author(s)
04/26/18	1.0	Initial release of Codebook for Medicare Encounter Records	Kathy Schneider, Rachel VanGilder, Chris Alleman

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the Medicare Encounter Records 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.

Quick Links: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

ADMTG_DGNS_CD

LABEL: Claim Admitting Diagnosis Code

DESCRIPTION: A diagnosis code on the institutional encounter 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).

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

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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.

TYPE: CHAR

LENGTH: 10

FILE(S): IP Base

SNF Base

HH Base

OP Base

SOURCE: Medicare Advantage Organizations (MAOs)

VALUES: -

COMMENT: -

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AT_PHYSN_TXNMY_CD

LABEL: Claim Attending Physician Taxonomy Code

DESCRIPTION: The health care provider taxonomy (HCPT) code used to indicate the attending provider's specialty. This is a unique identifier for a classification of health care specialty at a specialized level of defined medical activity within a medical field as created by the National Uniform Claim Committee (NUCC).

TYPE: CHAR

LENGTH: 10

FILE(S): IP Base

SNF Base

HH Base

OP Base

SOURCE: Medicare Advantage Organizations (MAOs)

VALUES: 10-digit alphanumeric

COMMENT: Additional information regarding the meaning of the NUCC taxonomy codes is available on their website. See, for example: http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

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BENE_CNTY_CD

LABEL: Beneficiary County Code from Claim (SSA)

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

TYPE: CHAR

LENGTH: 3

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.

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_DSCHRG_DT

LABEL: Beneficiary Discharge Date

DESCRIPTION: On an inpatient, SNF or Home Health claim, the date the beneficiary was discharged / transferred from the facility, or died.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

VALUES: -

COMMENT: -

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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, Medicare encounter, 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.

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

FILE(S): All Encounter Files

VALUES: -

COMMENT: -

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BENE_MDCR_STUS_CD

LABEL: Beneficiary Medicare Status Code

DESCRIPTION: This variable identifies how a beneficiary qualifies for Medicare benefits as of a particular date.

TYPE: CHAR

LENGTH: 2

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 10 = Aged without end-stage renal disease (ESRD)

11 = Aged with ESRD

20 = Disabled without ESRD

21 = Disabled with ESRD

31 = ESRD only

COMMENT: CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.

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BENE_MLG_CNTCT_ZIP_CD

LABEL: Beneficiary ZIP Code of Residence from Claim

DESCRIPTION: The ZIP code of the mailing address where the beneficiary may be contacted. It is the zip 5 and 4-digit extension as submitted on the encounter record.

TYPE: CHAR

LENGTH: 9

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: -

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BENE_RACE_CD

LABEL: Beneficiary Race Code

DESCRIPTION: Race code of the beneficiary

TYPE: CHAR

LENGTH: 1

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

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

COMMENT: CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.

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BENE_STATE

LABEL: State of beneficiary (postal abbreviation)

DESCRIPTION: This variable is the two-letter postal abbreviation for the state where the beneficiary lives.

TYPE: CHAR

LENGTH: 2

SOURCE: CMS Common Medicare Environment (CME) and CMS/Census Bureau crosswalk (derived)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 2-character postal state code

AK	=	Alaska	NC	=	North Carolina
AL	=	Alabama	ND	=	North Dakota
AR	=	Arkansas	NE	=	Nebraska
AZ	=	Arizona	NH	=	New Hampshire
CA	=	California	NJ	=	New Jersey
CO	=	Colorado	NM	=	New Mexico
CT	=	Connecticut	NV	=	Nevada
DC	=	District of Columbia	NY	=	New York
DE	=	Delaware	OH	=	Ohio
FL	=	Florida	OK	=	Oklahoma
GA	=	Georgia	OR	=	Oregon
HI	=	Hawaii	PA	=	Pennsylvania
IA	=	Iowa	PR	=	Puerto Rico
ID	=	Idaho	RI	=	Rhode Island
IL	=	Illinois	SC	=	South Carolina
IN	=	Indiana	SD	=	South Dakota
KS	=	Kansas	TN	=	Tennessee
KY	=	Kentucky	TX	=	Texas
LA	=	Louisiana	UT	=	Utah

MA	=	Massachusetts	VA	=	Virginia
MD	=	Maryland	VI	=	Virgin Islands
ME	=	Maine	VT	=	Vermont
MI	=	Michigan	WA	=	Washington
MN	=	Minnesota	WI	=	Wisconsin
MO	=	Missouri	WV	=	West Virginia
MS	=	Mississippi	WY	=	Wyoming
MT	=	Montana	Null	=	Unknown

COMMENT: CCW derived this variable by taking the SSA state/county code on the CME record for that beneficiary in the CMS enrollment database and linking it to the corresponding state postal abbreviation. If we could not find a state using this method, we set the variable equal to the state portion of the beneficiary's SSA state/county code. If that failed, we set the state equal to null.

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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.

TYPE: CHAR

LENGTH: 2

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES:

00 = unknown state	40 = Puerto Rico
01 = Alabama	41 = Rhode Island
02 = Alaska	42 = South Carolina
03 = Arizona	43 = South Dakota
04 = Arkansas	44 = Tennessee
05 = California	45 = Texas
06 = Colorado	46 = Utah
07 = Connecticut	47 = Vermont
08 = Delaware	48 = Virgin Islands
09 = District of Columbia	49 = Virginia
10 = Florida	50 = Washington
11 = Georgia	51 = West Virginia
12 = Hawaii	52 = Wisconsin
13 = Idaho	53 = Wyoming
14 = Illinois	54 = Africa
15 = Indiana	55 = California
16 = Iowa	56 = Canada & Islands
17 = Kansas	57 = Central America and West Indies
18 = Kentucky	58 = Europe
19 = Louisiana	59 = Mexico
20 = Maine	60 = Oceania
21 = Maryland	61 = Philippines
22 = Massachusetts	62 = South America
23 = Michigan	63 = U.S. Possessions

24 = Minnesota	64 = American Samoa
25 = Mississippi	65 = Guam
26 = Missouri	66 = Commonwealth of the Northern Marianas Islands
27 = Montana	67 = Texas
28 = Nebraska	68 = Florida
29 = Nevada	69 = Florida
30 = New Hampshire	70 = Kansas
31 = New Jersey	71 = Louisiana
32 = New Mexico	72 = Ohio
33 = New York	73 = Pennsylvania
34 = North Carolina	74 = Texas
35 = North Dakota	80 = Maryland
36 = Ohio	97 = Northern Marianas
37 = Oklahoma	98 = Guam
38 = Oregon	99 = With 000 county code is American Samoa;
39 = Pennsylvania	Null/missing = unknown state

COMMENT: CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.

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CLM_1ST_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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

There are additional E code fields available in this file. The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

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.

For home health services, this is the date care started for the HH services reported on the encounter record.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

VALUES: -

COMMENT: For HH, this date indicates the date the home health plan was established or last reviewed.

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.

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CLM_BPRVDR_ADR_ZIP_CD

LABEL: Billing Provider Zip Code

DESCRIPTION: This variable is the 9-digit zip code for the primary practice/business location of the physician receiving the payment or other transfer of value (i.e., the billing provider).

TYPE: CHAR

LENGTH: 9

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 9-digit ZIP code (may have leading zeros)

COMMENT: -

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CLM_BPRVDR_CITY_NAME

LABEL: Billing Provider Address - City

DESCRIPTION: This variable is the billing provider city name, as submitted on the encounter.

TYPE: CHAR

LENGTH: 30

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: -

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CLM_BPRVDR_USPS_STATE_CD

LABEL: Billing Provider Address – USPS State Code

DESCRIPTION: This variable is the billing provider's 2-character United States Postal Service (USPS) state code abbreviation, as submitted on the encounter.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES:

AK	=	Alaska	NC	=	North Carolina
AL	=	Alabama	ND	=	North Dakota
AR	=	Arkansas	NE	=	Nebraska
AZ	=	Arizona	NH	=	New Hampshire
CA	=	California	NJ	=	New Jersey
CO	=	Colorado	NM	=	New Mexico
CT	=	Connecticut	NV	=	Nevada
DC	=	District of Columbia	NY	=	New York
DE	=	Delaware	OH	=	Ohio
FL	=	Florida	OK	=	Oklahoma
GA	=	Georgia	OR	=	Oregon
HI	=	Hawaii	PA	=	Pennsylvania
IA	=	Iowa	PR	=	Puerto Rico
ID	=	Idaho	RI	=	Rhode Island
IL	=	Illinois	SC	=	South Carolina
IN	=	Indiana	SD	=	South Dakota
KS	=	Kansas	TN	=	Tennessee
KY	=	Kentucky	TX	=	Texas
LA	=	Louisiana	UT	=	Utah
MA	=	Massachusetts	VA	=	Virginia
MD	=	Maryland	VI	=	Virgin Islands

ME	=	Maine	VT	=	Vermont
MI	=	Michigan	WA	=	Washington
MN	=	Minnesota	WI	=	Wisconsin
MO	=	Missouri	WV	=	West Virginia
MS	=	Mississippi	WY	=	Wyoming
MT	=	Montana	XX	=	Unknown

COMMENT: -

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CLM_CHRT_RVW_SW

LABEL: Claim Chart Review Switch

DESCRIPTION: This variable is used to indicate whether the encounter record is a chart review record. Chart reviews are a type of encounter data record that allow Medicare Advantage Organizations (MAOs) to add or remove diagnoses that they identified through medical record reviews that were not initially reported on encounter data records.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: Y = Record is a chart review

Null/missing = Record is not a chart review

COMMENT: This is an indicator value that is set to 'Y' when MAOs report diagnoses obtained from medical record reviews (i.e., chart reviews) that were not initially reported on encounter data records when the MAO submitted the encounter. Otherwise, the value is set to null.

Chart review records may be submitted for any service type (including services that are not eligible for risk adjustment), and there are no limitations on the number of chart review records in totality or per encounter.

Additional details regarding the meaning and use of chart review records can be found in the Medicare Encounter Data User Guide.

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CLM_CNTL_NUM

LABEL: Claim Control Number

DESCRIPTION: The claim control number is an identifier assigned by the processing system (i.e., the Encounter Data System Contractor) to a claim.

This is the field that, in combination with the original claim control number, identifies a unique version of a service record.

TYPE: CHAR

LENGTH: 23

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: Multiple iterations of a single service (i.e., a particular type of claim for a specific service date for the person) are present in the Encounter RIFs; records are not limited to the final version of the encounter record. When multiple records for a service exist, the higher the claim control number, the later it was adjusted (i.e., the highest CLM_CNTL_NUM is the latest version of the encounter).

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CLM_DAY_CNT

LABEL: Day Count (Length of Stay)

DESCRIPTION: This is a derived field that calculates the beneficiary's length of stay in an inpatient or SNF setting.

TYPE: NUM

LENGTH: 4

SOURCE: CMS Integrated Data Repository (IDR)

FILE(S): IP Base

SNF Base

VALUES: -

COMMENT: The count of days is the (CLM_THRU_DT – CLM_FROM_DT)+1

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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. A unique identifier of a hospital case type that is based on similar clinical problems.

TYPE: CHAR

LENGTH: 3

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

VALUES: -

COMMENT: This is an MAO submitted field and may be different than the derived DRG code (variable called DRVD_DRG_CD).

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

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient Base

SNF Base

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

COMMENT: -

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CLM_FAC_TYPE_CD

LABEL: Claim Facility Type Code

DESCRIPTION: The type of facility.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES:
1 = Hospital
2 = Skilled Nursing Facility (SNF)
3 = Home Health Agency (HHA)
4 = Religious Non-medical (hospital)
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).

Note that sometimes 3 variables are used for "type of bill", where the 3rd digit is the claim frequency code (CLM_FREQ_CD).

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CLM_FINL_ACTN_IND

LABEL: Claim Final Action Indicator

DESCRIPTION: This field is stored in the CMS Integrated Data Repository (IDR) as the final action indicator; however, CMS has verified that for 2015 encounter records, this field should not be used to identify the final version of the record. Note that the term "final action" is used differently in encounter data, compared to fee-for-service (FFS) claims.

TYPE: CHAR

LENGTH: 1

SOURCE: CMS Integrated Data Repository (IDR)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: Y = Final action and the claim is not voided

N = Subsequent adjustments to the claim exist or the final action was to void the claim

COMMENT: Duplicate services across multiple final action records may exist, and users should make appropriate adjustments when identifying distinct services. Additional information regarding identification of distinct services – or identification of populations appears in the Medicare Encounter Data User Guide.

Final action records are only indicative of the latest accepted record within a claim family that has been linked by the Medicare Advantage Organization (MAO) and may not be indicative of risk-adjustment eligibility.

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

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)
A = Admission election notice (when hospice or Religious Nonmedical Health Care Institution is submitting the HCFA-1450 as an admission notice; this is to establish a hospice benefit period)
G = Common Working File (NCH) generated adjustment claim
H = CMS generated adjustment claim
I = Misc. adjustment claim (e.g., initiated by intermediary or QIO)

COMMENT: This code is used for encounter final action processing for all encounter claim types, including carrier.

The encounter bill type frequency codes utilize a similar nomenclature to Medicare fee for service bill type frequency codes. This field can be used in determining the "type of bill" for an institutional claim. Often the 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. Many different types of services can be appear on an encounter 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).

A 3-part type of bill is the concatenation of three variables:

-facility type (CLM_FAC_TYPE_CD)

-service classification type (CLM_SRVC_CLSFCTN_TYPE_CD)

- claim frequency code (CLM_FREQ_CD).

^ Back to TOC ^

CLM_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').

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: The "from" date on the claim may not always represent the first date of services, particularly for Home Health 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.

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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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

VALUES:

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.

9 = Unknown - Information not available.

COMMENT: -

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CLM_LINE_NUM

LABEL: Claim Line Number

DESCRIPTION: This variable identifies an individual line number on an encounter record claim.

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

All revenue center records or claim lines on a given claim have the same encounter join key (variable called ENC_JOIN_KEY).

TYPE: NUM

LENGTH: 13

SOURCE: CCW

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

Carrier Line

DME Line

VALUES: -

COMMENT: -

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CLM_LTST_CLM_IND

LABEL: Latest Claim Indicator

DESCRIPTION: This variable indicates if the record is the latest action.

TYPE: CHAR

LENGTH: 1

SOURCE: CMS Integrated Data Repository (IDR)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: Y = Latest action and the record could be a chart review

N = Subsequent adjustments or resubmissions to the claim exist

Null/missing = not latest record

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. The medical record number has special significance for chart review encounters. When the chart review's purpose is to delete a diagnosis code from the claim, the medical record number should be '8'.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 8 = MAO is deleting the diagnoses on the record.

Null/missing.

COMMENT: This variable may be null/missing. No values other than 8 are in this field.

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CLM_OBSLT_DT

LABEL: Claim Obsolete Date

DESCRIPTION: The date the claim is no longer the latest action (including chart reviews that link to an original claim).

TYPE: DATE

LENGTH: 8

SOURCE: CMS Integrated Data Repository (IDR)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: Note that the CLM_OBSLT_DT='12-31-9999' for claims without any subsequent adjustments. When the record is superseded by subsequent adjustments, then the CLM_OBSLT_DT=(EDPS_CREATE_DT of the record with the latest action – 1).

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CLM_ORIG_CNTL_NUM

LABEL: Claim Original Control Number

DESCRIPTION: This variable is the original intermediary control number (ICN) which is present on adjustment encounter, representing the ICN of the original transaction now being adjusted.

TYPE: CHAR

LENGTH: 23

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: When an encounter record has been adjusted, the claim control number (CLM_CNTL_NUM) for the version of the record that is being adjusted appears in the CLM_ORIG_CNTL_NUM field – and then a new CLM_CNTL_NUM is assigned to this updated record. A null/missing CLM_ORIG_CNTL_NUM indicates that a prior encounter record has not been adjusted by the Medicare Advantage Organization (MAO). Generally, this implies that it is the first occurrence of an encounter service record, but occasionally, multiple record submissions for the same service may appear as original encounters.

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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 1st diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

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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 2nd diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 3rd diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 4th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 5th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 6th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 7th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 8th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 9th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 10th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 11th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 12th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 13th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 14th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 15th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 16th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 17th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 18th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 19th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 20th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 21st diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

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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 22nd diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

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 23rd diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

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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 24th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

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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 25th diagnosis was present on admission.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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

COMMENT: The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_ IND_SW1 - CLM_E_POA_ IND_SW10.

^ Back to TOC ^

CLM_RCPT_DT

LABEL: Claim Receipt Date

DESCRIPTION: The date the encounter was submitted into the CMS Encounter Data System (EDS).

TYPE: DATE

LENGTH: 8

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: It is the transaction control number associated with the date the batch of encounter records was submitted. This date will be equal to or less than the EDPS_CREATE_DT.

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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 or encounter record that may affect payer processing.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Condition Code File

SNF Condition Code File

HH Condition Code File

OP Condition Code File

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

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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.

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.

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.

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.

50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement.

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.

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.

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.

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

AB = Abortion Performed due to Incest)

AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality

AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or exacerbated by the Pregnancy itself

AE = Abortion Performed due to physical health of mother that is not life endangering

AF = Abortion performed due to emotional/psychological health of mother
AG = Abortion performed due to social economic reasons
AH = Elective Abortion
AI = Sterilization
AJ = Payer Responsible for copayment
AK = Air Ambulance Required - For ambulance claims. Time needed to transport poses a threat.
AL = Specialized Treatment/bed Unavailable - For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility.
AM = Non-emergency Medically Necessary Stretcher Transport Required - For ambulance claims. Non-emergency medically necessary stretcher transport required.
AN = Preadmission Screening Not Required – person meets the criteria for an exemption from preadmission screening.
B0 = Medicare Coordinated Care Demonstration Program - patient is a participant in a Medicare Coordinated Care Demonstration
B1 = Beneficiary ineligible for demonstration program
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.
B4 = Admission Unrelated to Discharge – Admission unrelated to discharge on same day.
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 - 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

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 or encounter record that may affect payer processing.

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

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Occurrence Code File

SNF Occurrence Code File

HH Occurrence Code File

OP Occurrence Code File

VALUES: 01 THRU 09 = Accident

10 THRU 19 = Medical condition

20 THRU 39 = Insurance related

40 THRU 69 = Service related

A1 - A3 = Miscellaneous

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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).

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.

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.

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 or encounter record that may affect payer processing.

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

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Occurrence Code File

SNF Occurrence Code File

HH Occurrence Code File

OP Occurrence Code File

VALUES: -

COMMENT: -

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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).

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Span Code File

SNF Span Code File

HH Span Code File

OP Span Code File

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.

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

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).

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Span Code File

SNF Span Code File

HH Span Code File

OP Span Code File

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).

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Span Code File

SNF Span Code File

HH Span Code File

OP Span Code File

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

VALUES: 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 -– 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)

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

Null/missing = unknown

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

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 appear on an institutional encounter record, 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_SUBSCR_ADR_ZIP_CD

LABEL: Medicare Subscriber Address – ZIP Code

DESCRIPTION: This field represents the subscriber's mailing ZIP code. It is the zip 5 and 4-digit extension as submitted on the encounter record.

TYPE: CHAR

LENGTH: 9

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: -

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CLM_SUBSCR_CITY_NAME

LABEL: Medicare Subscriber Address – City

DESCRIPTION: This variable is the Medicare subscriber's city name, as submitted on the encounter record.

TYPE: CHAR

LENGTH: 30

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: -

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CLM_SUBSCR_USPS_STATE_CD

LABEL: Medicare Subscriber Address – USPS State Code

DESCRIPTION: This variable is the Medicare subscriber's 2-character United States Postal Service (USPS) state code abbreviation, as submitted on the encounter record.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES:

AA	=	Armed Forces, Americas	MO	=	Missouri
AE	=	Armed Forces, Europe/Middle East/Africa/Canada	MP	=	Northern Mariana Islands
AK	=	Alaska	MS	=	Mississippi
AL	=	Alabama	MT	=	Montana
AP	=	Armed Forces, Pacific	NC	=	North Carolina
AR	=	Arkansas	ND	=	North Dakota
AS	=	American Samoa	NE	=	Nebraska
AZ	=	Arizona	NH	=	New Hampshire
CA	=	California	NJ	=	New Jersey
CO	=	Colorado	NM	=	New Mexico
CT	=	Connecticut	NV	=	Nevada
DC	=	District of Columbia	NY	=	New York
DE	=	Delaware	OH	=	Ohio
FL	=	Florida	OK	=	Oklahoma
FM	=	Federated States of Micronesia	OR	=	Oregon
GA	=	Georgia	PA	=	Pennsylvania
GU	=	Guam	PR	=	Puerto Rico
HI	=	Hawaii	PW	=	Palau
IA	=	Iowa	RI	=	Rhode Island
ID	=	Idaho	SC	=	South Carolina
IL	=	Illinois	SD	=	South Dakota
IN	=	Indiana	TN	=	Tennessee

KS	=	Kansas	TX	=	Texas
KY	=	Kentucky	UT	=	Utah
LA	=	Louisiana	VA	=	Virginia
MA	=	Massachusetts	VI	=	Virgin Islands
MD	=	Maryland	VT	=	Vermont
ME	=	Maine	WA	=	Washington
MH	=	Marshall Islands	WI	=	Wisconsin
MI	=	Michigan	WV	=	West Virginia
MN	=	Minnesota	WY	=	Wyoming
			XX	=	Unknown

COMMENT: -

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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').

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): All Encounter Files

VALUES: -

COMMENT: 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 encounter (variable called BENE_DSCHRG_DT).

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_TYPE_CD

LABEL: Claim Type Code

DESCRIPTION: The type of claim that was submitted. There are different claim types for each major category of health care provider.

TYPE: CHAR

LENGTH: 4

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): All files – every base/revenue/line/trailer

VALUES:

Encounter File	CLM_TYPE_CD		Description
IP	4011	=	Hospital Inpatient
	4041	=	Religious Nonmedical Health Care Institutions - Hospital Inpatient
SNF	4018	=	Hospital Swing Beds
	4021	=	SNF Skilled Nursing Inpatient
	4028	=	SNF Skilled Nursing Swing Beds
HHA	4032	=	Home Health + Inpatient (covered by Medicare Part B – not Part A)
	4033	=	Home Health + Outpatient
OP	4012	=	Hospital Inpatient (covered by Medicare Part B – not Part A)
	4013	=	Hospital Outpatient
	4014	=	Hospital Laboratory Services Provided to Non-patients
	4022	=	SNF Skilled Nursing Inpatient (covered by Medicare Part B – not Part A)
	4023	=	SNF Skilled Nursing Outpatient
	4034	=	Home Health + Laboratory Services Provided to Non-patients
	4071	=	Clinic (RHC) Rural Health
	4072	=	Clinic (ESRD) Renal Dialysis Hospital Based or Independent
	4073	=	Clinic Freestanding
	4074	=	Clinic (ORF) Outpatient Rehab Facility
	4075	=	Clinic (CORF) Comprehensive Outpatient Rehab Facility
	4076	=	Clinic (CMHC) Community Mental Health Centers
	4077	=	Clinic (FQHC) Federal Qualified Health Center
	4079	=	Clinic - Other
	4083	=	Special Facility (ASC) Ambulatory Surgery Center
	4085	=	Special Facility (CAH) Critical Access Hospital
	4089	=	Special Facility - Other

Carrier	4700	=	Professional
DME	4800	=	DME

COMMENT: -

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CLM_VAL_CD

LABEL: Claim Value Code

DESCRIPTION: The code indicating a monetary condition which was used on an institutional claim.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Value Code File

SNF Value Code File

HH Value Code File

OP Value Code File

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.

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).

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).

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.

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

49 = Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period

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. The value code amount field reflects the CBSA code.

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 – code indicates the percentage of charity care eligibility for the patient.

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.

80 = Covered Days - the number of days covered by the primary payer as qualified by the payer.

81 = Non-Covered Days - days of care not covered by the primary payer.

82 = Coinsurance Days - The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing bed days occurring after the 20th and before the 101st day in a single spell of illness.

83 = Lifetime Reserve Days - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.

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.

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.

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.

AB = Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to 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

C3 = Estimated Responsibility Payer C

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.

D5 = Result of last Kt/V - For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service. (eff. 7/1/10)

FC = Patient Paid Amount - The amount the provider has received from the patient toward payment of this bill (7/1/08).

FD = Credit Received from the Manufacturer for a Replaced Medical Device - the amount the provider has received from a medical device manufacturer as credit for a replaced device. (eff. 7/1/08)

Y3 = Part B coinsurance - Amount of Part B coinsurance for this demonstration project claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

COMMENT: -

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CNTRCT_NUM

LABEL: Medicare Part C Contract Number

DESCRIPTION: This variable is the unique identification for a managed care organization (MCO) enabling the entity to provide coverage to eligible Medicare beneficiaries.

TYPE: CHAR

LENGTH: 5

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 4-digit alphanumeric

COMMENT: The first character of the contract ID is a letter that indicates the type of plan. For local managed care contracts, it begins with 'H' or '9'; for regional managed care contracts, it begins with 'R'; for prescription drug plans (PDPs), it begins with 'S'; for fallback contracts, it begins with 'F', for Employer- Direct PDP and Employer-Direct PFFS it begins with 'E'. The remaining 4 digits are numeric.

You need to know both the contract number and plan benefit package number (CNTRCT_PBP_NUM) in order to identify the specific plan in which a beneficiary was enrolled.

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CNTRCT_PBP_NUM

LABEL: Medicare Part C Plan Benefit Package (PBP) Number

DESCRIPTION: The variable is the plan benefit package (PBP) number for the beneficiary's managed care plan. CMS assigns an identifier to each PBP within a contract that a plan sponsor has with CMS.

TYPE: CHAR

LENGTH: 3

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 3-digit numeric

COMMENT: You need to know both the contract number (variable called CNTRCT_NUM) and plan benefit package number (plan ID) in order to identify the specific plan in which a beneficiary was enrolled. CNTRCT_PBP_NUM is not submitted by the MAO on an encounter data record; the MAO only submits the contract ID. Instead the plan ID is assigned by CMS based on the beneficiary's enrollment data for the claim dates of service. CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data

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DOB_DT

LABEL: Date of Birth from Encounter

DESCRIPTION: The beneficiary's date of birth, as recorded on the encounter record

TYPE: DATE

LENGTH: 8

SOURCE: CMS Common Medicare Environment (CME)

FILE(S): IP Base

SNF Base

HH Base

Carrier Base

DME Base

VALUES: -

COMMENT: -

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DRVD_DRG_CD

LABEL: Derived MS-Diagnosis Related Group Code (MS-DRG)

DESCRIPTION: The Medicare Severity diagnostic related group (MS-DRG) to which a hospital claim belongs for prospective payment purposes that is derived by the Encounter Data Processing System (EDPS).

TYPE: CHAR

LENGTH: 4

SOURCE: Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

VALUES: -

COMMENT: This element is returned from 3M . It is calculated based on the diagnoses, procedures, age, sex, discharge status on an encounter record.

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EDPS_CREATE_DT

LABEL: Encounter Data Processing System (EDPS) Create Date

DESCRIPTION: The date that an encounter record was created on the CMS Encounter Data Processing System (EDPS) database.

TYPE: DATE

LENGTH: 8

SOURCE: CMS Encounter Data System (EDS)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: The CLM_RCPT_DT is derived from the claim control number created by the CMS Encounter Data System, and it will typically be equal to or less than the EDPS_CREATN_DT.

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ENC_JOIN_KEY

LABEL: Unique encounter join key

DESCRIPTION: This is a unique join key assigned by CCW/CMS to assist the user in joining the base claim to a line claim for each encounter record.

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

FILE(S): All Encounter Files

VALUES: -

COMMENT: Each IP, SNF, HH or OP Encounter base record has at least one revenue center record.

Each Carrier or DME Encounter base record has at least one line record.

All revenue center records or lines on a given encounter record have the same ENC_JOIN_KEY. It is used to link the revenue lines together and/or to the base claim.

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GNDR_CD

LABEL: Gender Code from Encounter record

DESCRIPTION: The sex of a beneficiary.

TYPE: CHAR

LENGTH: 1

SOURCE: CMS Common Medicare Environment (CME)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 0 = Unknown

1 = Male

2 = Female

COMMENT: -

^ Back to TOC ^

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 encounter record.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

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 encounter record.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

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 encounter record.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

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 to identify the revenue center or line item services for the encounter record.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): OP Revenue

Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

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 Encounter 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).

TYPE: CHAR

LENGTH: 5

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

Carrier Line

DME Line

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.

^ Back to TOC ^

ICD_DGNS_CD1

LABEL: Claim Diagnosis Code I

DESCRIPTION: The diagnosis code identifying the beneficiary's principal diagnosis.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD2

LABEL: Claim Diagnosis Code II

DESCRIPTION: The diagnosis code in the 2nd position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD3

LABEL: Claim Diagnosis Code III

DESCRIPTION: The diagnosis code in the 3rd position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD4

LABEL: Claim Diagnosis Code IV

DESCRIPTION: The diagnosis code in the 4th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD5

LABEL: Claim Diagnosis Code V

DESCRIPTION: The diagnosis code in the 5th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD6

LABEL: Claim Diagnosis Code VI

DESCRIPTION: The diagnosis code in the 6th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD7

LABEL: Claim Diagnosis Code VII

DESCRIPTION: The diagnosis code in the 7th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD8

LABEL: Claim Diagnosis Code VIII

DESCRIPTION: The diagnosis code in the 8th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD9

LABEL: Claim Diagnosis Code IX

DESCRIPTION: The diagnosis code in the 9th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD10

LABEL: Claim Diagnosis Code X

DESCRIPTION: The diagnosis code in the 10th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD11

LABEL: Claim Diagnosis Code XI

DESCRIPTION: The diagnosis code in the 11th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD12

LABEL: Claim Diagnosis Code XII

DESCRIPTION: The diagnosis code in the 12th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD13

LABEL: Claim Diagnosis Code XIII

DESCRIPTION: The diagnosis code in the 13th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD14

LABEL: Claim Diagnosis Code XIV

DESCRIPTION: The diagnosis code in the 14th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD15

LABEL: Claim Diagnosis Code XV

DESCRIPTION: The diagnosis code in the 15th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD16

LABEL: Claim Diagnosis Code XVI

DESCRIPTION: The diagnosis code in the 16th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD17

LABEL: Claim Diagnosis Code XVII

DESCRIPTION: The diagnosis code in the 17th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD18

LABEL: Claim Diagnosis Code XVIII

DESCRIPTION: The diagnosis code in the 18th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD19

LABEL: Claim Diagnosis Code XIX

DESCRIPTION: The diagnosis code in the 19th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD20

LABEL: Claim Diagnosis Code XX

DESCRIPTION: The diagnosis code in the 20th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD21

LABEL: Claim Diagnosis Code XXI

DESCRIPTION: The diagnosis code in the 21st position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD22

LABEL: Claim Diagnosis Code XXII

DESCRIPTION: The diagnosis code in the 22nd position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD23

LABEL: Claim Diagnosis Code XXIII

DESCRIPTION: The diagnosis code in the 23rd position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD24

LABEL: Claim Diagnosis Code XXIV

DESCRIPTION: The diagnosis code in the 24th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

ICD_DGNS_CD25

LABEL: Claim Diagnosis Code XXV

DESCRIPTION: The diagnosis code in the 25th position identifying the condition(s) for which the beneficiary is receiving care.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

ICD_DGNS_E_CD2

LABEL: Claim Diagnosis E Code II

DESCRIPTION: The code used to identify the 2nd external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

ICD_DGNS_E_CD3

LABEL: Claim Diagnosis E Code III

DESCRIPTION: The code used to identify the 3rd external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

ICD_DGNS_E_CD5

LABEL: Claim Diagnosis E Code V

DESCRIPTION: The code used to identify the 5th external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

ICD_DGNS_E_CD6

LABEL: Claim Diagnosis E Code VI

DESCRIPTION: The code used to identify the 6th external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

ICD_DGNS_E_CD7

LABEL: Claim Diagnosis E Code VII

DESCRIPTION: The code used to identify the 7th external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

ICD_DGNS_E_CD8

LABEL: Claim Diagnosis E Code VIII

DESCRIPTION: The code used to identify the 8th external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

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ICD_DGNS_E_CD9

LABEL: Claim Diagnosis E Code IX

DESCRIPTION: The code used to identify the 9th external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

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ICD_DGNS_E_CD10

LABEL: Claim Diagnosis E Code X

DESCRIPTION: The code used to identify the 10th external cause of injury, poisoning, or other adverse effect.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.

The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

^ Back to TOC ^

ICD_DGNS_VRSN_CD1

LABEL: Claim Diagnosis 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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

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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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.

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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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

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.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

^ Back to TOC ^

ICD_PRCDR_CD11

LABEL: Claim Procedure Code XI

DESCRIPTION: The code that indicates the procedure performed during the period covered by the institutional claim.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

^ Back to TOC ^

ICD_PRCDR_CD12

LABEL: Claim Procedure Code XII

DESCRIPTION: The code that indicates the procedure performed during the period covered by the institutional claim.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

^ Back to TOC ^

ICD_PRCDR_CD13

LABEL: Claim Procedure Code XIII

DESCRIPTION: The code that indicates the procedure performed during the period covered by the institutional claim.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

^ Back to TOC ^

LINE_1ST_EXPNS_DT

LABEL: Line First Expense Date

DESCRIPTION: Beginning date (1st expense) for this line item service on the non-institutional encounter record.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

LINE_LAST_EXPNS_DT

LABEL: Line Last Expense Date

DESCRIPTION: The ending date (last expense) for the line item service on the non-institutional encounter record.

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.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

LINE_LTST_CLM_IND

LABEL: Line Latest Claim Indicator

DESCRIPTION: Indicates if the line on the encounter record is the latest action.

TYPE: CHAR

LENGTH: 1

SOURCE: CMS Integrated Data Repository (IDR)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

Carrier Line

DME Line

VALUES: Y = Latest action and the record could be a chart review

N = Subsequent adjustments or resubmissions to the claim line exist.

COMMENT: -

^ Back to TOC ^

LINE_NDC_CD

LABEL: Line National Drug Code (NDC)

DESCRIPTION: This field is the National Drug Code (NDC) identifying the specific drug.

TYPE: CHAR

LENGTH: 11

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

LINE_PLACE_OF_SRVC_CD

LABEL: Line Place of Service Code

DESCRIPTION: The code indicating where the service was performed; the place of service.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

DME Line

VALUES:

00 = Unknown

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 = Place of employment/worksite

19 = Off campus – outpatient hospital

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

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.

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.

0D = Unknown

0O = Unknown

C0 = Unknown

CC = Unknown

DW = Unknown

JC = Unknown

N0 = Unknown

N4 = Unknown

N5 = Unknown

N6 = Unknown

ND = Unknown

P0 = Unknown

SE = Unknown

XY = Unknown

ZZ = Unknown

COMMENT: -

^ Back to TOC ^

LINE_RX_NUM

LABEL: Carrier Line RX Number

DESCRIPTION: The pharmacy's internal invoice number on pharmaceutical claims.

TYPE: CHAR

LENGTH: 30

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

VALUES: -

COMMENT: -

^ Back to TOC ^

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.

TYPE: NUM

LENGTH: 12

SOURCE: CMS Encounter Data System (EDS)

FILE(S): Carrier Line

DME Line

VALUES: 0 – XXXX (numeric values may include decimals)

COMMENT: -

^ Back to TOC ^

OP_PHYSN_NPI

LABEL: Claim Operating Physician NPI Number

DESCRIPTION: On an institutional encounter record, the National Provider Identifier (NPI) number assigned to uniquely identify the physician with the primary responsibility for performing the surgical procedure(s).

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

ORG_NPI

LABEL: Organization NPI Number

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

For a non-institutional claim or encounter record, this is the NPI number of the billing provider on the claim.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: -

^ Back to TOC ^

ORG_TXNMY_CD

LABEL: Organization Taxonomy Code

DESCRIPTION: This variable is the health care provider taxonomy (HCPT) code used to indicate the billing provider's specialty. This is a unique identifier for a classification of health care specialty at a specialized level of defined medical activity within a medical field as created by the National Uniform Claim Committee (NUCC).

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: Taxonomy codes are assigned by the National Uniform Claims Committee (NUCC). For a current list of NUCC Provider Taxonomy Codes and Descriptions see the Code Sets link at http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

^ Back to TOC ^

OT_PHYSN_NPI

LABEL: Claim Other Physician NPI Number

DESCRIPTION: On an institutional claim or encounter record, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

COMMENT: There are additional physician identifiers on the encounter record, including the attending physician (AT_PHYSN_NPI) and, depending on the claim type, the operating physician (OP_PHYSN_NPI), rendering physician (RNDRNG_PHYSN_NPI) or referring physician (RFRG_PHYSN_NPI).

^ Back to TOC ^

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.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT2

LABEL: Claim Procedure Code II Date

DESCRIPTION: The date on which the 2nd procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT3

LABEL: Claim Procedure Code III Date

DESCRIPTION: The date on which the 3rd procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT4

LABEL: Claim Procedure Code IV Date

DESCRIPTION: The date on which the 4th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT5

LABEL: Claim Procedure Code V Date

DESCRIPTION: The date on which the 5th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT6

LABEL: Claim Procedure Code VI Date

DESCRIPTION: The date on which the 6th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT7

LABEL: Claim Procedure Code VII Date

DESCRIPTION: The date on which the 7th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT8

LABEL: Claim Procedure Code VIII Date

DESCRIPTION: The date on which the 8th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT9

LABEL: Claim Procedure Code IX Date

DESCRIPTION: The date on which the 9th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT10

LABEL: Claim Procedure Code X Date

DESCRIPTION: The date on which the 10th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT11

LABEL: Claim Procedure Code XI Date

DESCRIPTION: The date on which the 11th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT12

LABEL: Claim Procedure Code XII Date

DESCRIPTION: The date on which the 12th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

PRCDR_DT13

LABEL: Claim Procedure Code XIII Date

DESCRIPTION: The date on which the 13th procedure was performed.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

OP Base

VALUES: -

COMMENT: -

^ Back to TOC ^

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).

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: -

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

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.

^ Back to TOC ^

PRVDR_NPI

LABEL: Line Rendering Physician NPI

DESCRIPTION: The National Provider Identifier (NPI) assigned to the rendering provider.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

DME Line

VALUES: -

COMMENT: -

^ Back to TOC ^

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 encounter record.

Assigned by the Medicare Advantage Organization (MAO) based on the corresponding provider identification number (performing NPI).

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

DME Line

VALUES:
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)
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
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
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)
44 = Infectious disease
46 = Endocrinology
48 = Podiatry
50 = Nurse practitioner
62 = Psychologist (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist (private practice)
66 = Rheumatology
67 = Occupational therapist (private practice)
68 = Clinical psychologist
72 = Pain Management
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
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
97 = Physician assistant
98 = Gynecologist/oncologist
99 = Unknown physician specialty

COMMENT: -

^ Back to TOC ^

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.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

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.

04 = Discharged/transferred to intermediate care facility (ICF).

05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).

06 = Discharged/transferred to home care of organized home health service organization.

07 = Left against medical advice or discontinued care.

09 = Admitted as an inpatient to this hospital. 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)

41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)

43 = Discharged/transferred to a federal hospital

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

62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital.

63 = Discharged/transferred to a long term care hospitals.

64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare

65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital.

66 = Discharged/transferred to a Critical Access Hospital (CAH)

69 = Discharged/transferred to a designated disaster alternative care site (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 (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 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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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.

TYPE: CHAR

LENGTH: 4

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

VALUES: 0001 = Total charge

0022 = SNF encounter. This code may appear multiple times on an encounter to identify different HIPPS Rate Code/assessment periods.
0023 = Home Health services. This code may appear multiple times on an encounter to identify different HIPPS/Home Health Resource Groups (HRG).
0024 = Inpatient Rehabilitation Facility services.
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-angiocardiography
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
0522 = Free-standing clinic-Home visit by RHC/FQHC practitioner
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
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
0526 = Free-standing clinic-urgent care
0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area
0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g. scene of accident)
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 moniter
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
0901 = Behavior Health Treatment/Services - electroshock treatment
0902 = Behavior Health Treatment/Services - milieu therapy
0903 = Behavior Health Treatment/Services - play therapy
0904 = Behavior Health Treatment/Services - activity therapy
0905 = Behavior Health Treatment/Services - intensive outpatient services-psychiatric
0906 = Behavior Health Treatment/Services - intensive outpatient services-chemical dependency
0907 = Behavior Health Treatment/Services - community behavioral health program-day treatment
0909 = Reserved for National Use

0910 = Behavioral Health Treatment/Services-Reserved for National Assignment
0911 = Behavioral Health Treatment/Services-rehabilitation
0912 = Behavioral Health Treatment/Services-partial hospitalization-less intensive
0913 = Behavioral Health Treatment/Services-partial hospitalization-intensive
0914 = Behavioral Health Treatment/Services-individual therapy
0915 = Behavioral Health Treatment/Services-group therapy
0916 = Behavioral Health Treatment/Services-family therapy
0917 = Behavioral Health Treatment/Services-biofeedback
0918 = Behavioral Health Treatment/Services-testing
0919 = Behavioral Health Treatment/Services-other
0920 = Other diagnostic services-general classification
0921 = Other diagnostic services-peripheral vascular lab
0922 = Other diagnostic services-electromyelogram
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

COMMENT: -

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REV_CNTR_FROM_DT

LABEL: Revenue Center From Date

DESCRIPTION: This is the beginning date of service for the line item.

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

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'.

TYPE: CHAR

LENGTH: 24

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

VALUES: -

COMMENT: 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).

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REV_CNTR_NDC_QTY

LABEL: Revenue Center National Drug Code (NDC) Quantity

DESCRIPTION: The quantity dispensed for the drug reflected on the revenue center line item.

TYPE: NUM

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

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: The code used to indicate the unit of measurement for the drug that was administered.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

VALUES:

F2 = International Unit
GR = Gram
ML = Milliliter
UN = Unit
VY = Link Sequence Number (to report components for compound drug)
XZ = Prescription Number

COMMENT: The quantity of the drug dispensed is indicated in the variable called REV_CNTR_NDC_QTY.

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REV_CNTR_RNDRNG_PHYSN_NPI

LABEL: Revenue Center Rendering Physician NPI

DESCRIPTION: This variable is the National Provider Identifier (NPI) for the physician who rendered the services on the revenue center record.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

VALUES: -

COMMENT: -

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REV_CNTR_THRU_DT

LABEL: Revenue Center Thru Date

DESCRIPTION: This is the ending date of service for the line item

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

VALUES: -

COMMENT: -

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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 or encounter record.

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.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue

SNF Revenue

HH Revenue

OP Revenue

VALUES: 0 - XXXXXX

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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RFRG_PHYSN_NPI

LABEL: Carrier/DME Referring Physician NPI Number

DESCRIPTION: The national provider identifier (NPI) number of the physician who referred the beneficiary or the physician who ordered the Part B services or durable medical equipment (DME).

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base

DME Base

VALUES: -

COMMENT: -

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RLT_COND_CD_SEQ

LABEL: Claim Related Condition Code Sequence

DESCRIPTION: The sequence number of the claim related condition code (variable called CLM_RLT_COND_CD).

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

FILE(S): IP Condition Code File

SNF Condition Code File

HH Condition Code File

OP Condition Code File

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).

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

FILE(S): IP Occurrence Code File

SNF Occurrence Code File

HH Occurrence Code File

OP Occurrence Code File

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).

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

FILE(S): IP Span Code File

SNF Span Code File

HH Span Code File

OP Span Code File

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).

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

FILE(S): IP Value Code File

SNF Value Code File

HH Value Code File

OP Value Code File

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 on the record.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base

SNF Base

HH Base

OP Base

VALUES: -

COMMENT: -

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RSN_VISIT_CD1

LABEL: Reason for Visit Diagnosis Code I

DESCRIPTION: The 1st diagnosis code used to identify the patient's reason for the Home Health (HH) encounter record or Hospital Outpatient visit.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): HH Base

OP Base

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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RSN_VISIT_CD2

LABEL: Reason for Visit Diagnosis Code II

DESCRIPTION: The 2nd diagnosis code used to identify the patient's reason for the Home Health (HH) encounter record.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): HH Base

OP Base

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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RSN_VISIT_CD3

LABEL: Reason for Visit Diagnosis Code III

DESCRIPTION: The 3rd diagnosis code used to identify the patient's reason for the Home Health (HH) encounter record.

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): HH Base

OP Base

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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SAMPLE_GROUP

LABEL: CCW Beneficiary Random Sample Group

DESCRIPTION: This variable indicates if the beneficiary is part of a random 1, 5, 15, or 20 percent sample of Medicare beneficiaries that the CCW creates using standard CMS processes. All associated encounter records for the sampled beneficiaries are identified in the encounter files.

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES:
01 = Beneficiary included in the 1 percent sample for the year
04 = Beneficiary included in the 4 percent sample for the year
15 = Beneficiary included in the 15 percent sample for the year
Null/missing = Beneficiary not included in any sample group for the year

COMMENT: To use the random 5 percent sample, users must combine the 1 and 4 percent samples (i.e., specify that SAMPLE_GROUP can equal “01” or “04”). To use the 20 percent sample, users must combine the 1, 4, and 15 percent samples (i.e., specify that SAMPLE_GROUP can equal “01”, “04”, or “15”).

Beneficiaries are assigned to sample groups each year based on the last two digits of their Medicare Claim Account Numbers (CANs).

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SRVC_MONTH

LABEL: Service Month

DESCRIPTION: The CCW-derived service month indicates the month and year when the service was provided, based on the claim through date (CLM_THRU_DT).

TYPE: DATE

LENGTH: 6

SOURCE: CCW

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: 201501 – 201512

COMMENT: This field can be used to obtain a subset of encounter records for analytic purposes.

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TAX_NUM

LABEL: Provider Tax Number

DESCRIPTION: The federal taxpayer identification number (TIN) that identifies the provider/physician/practice/supplier to whom payment is made for the service.

TYPE: CHAR

LENGTH: 10

SOURCE: CCW

FILE(S): IP Base

SNF Base

HH Base

OP Base

Carrier Base

DME Base

VALUES: -

COMMENT: This number may be an employer identification number (EIN) or social security number (SSN).

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