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Medicare Fee-For-Service (FFS) Claims (version L) Codebook

MARCH 2025 | VERSION 1.13

Revision Log

Date	Changed by	Revisions	Version
March 2025	K. Schneider	Removed field for beneficiary sex because it is available in the Master Beneficiary Summary File. Added valid values to LINE_PLACE_OF_SRVC_CD, DEMO_ID_NUM, and CLM_FREQ_CD. Clarified the comment section of CLM_THRU_DT. Embellished description for CLM_NEXT_GNRTN_ACO_IND_CD1–5. Removed values to comply with NUBC™ licensing for: CLM_IP_ADMSN_TYPE_CD, CLM_RLT_COND_CD, CLM_RLT_OCRNC_CD, CLM_SPAN_CD, CLM_SRC_IP_ADMSN_CD, CLM_VAL_CD, PTNT_DSCHRG_STUS_CD, and REV_CNTR	1.13
August 2024	K. Schneider	Added values and adjusted value descriptions for CLM_NEXT_GNRTN_ACO_IND_CD1-5, DEMO_ID_NUM, LINE_OTHR_APLD_IND_CD1-7, REV_CNTR_PMT_MTHD_IND_CD, and REV_CNTR_STUS_IND_CD. Adjusted two historical values for CLM_VAL_CD. Added state values for the PRVDR_NUM and related comment in PRVDR_STATE_CD. Inserted caution re: NCH_PTNT_STUS_IND_CD	1.12
January 2024	K. Schneider	Added new fields and corresponding descriptions for BLG_PRVDR_SPCLTY_CD1, BLG_PRVDR_SPCLTY_CD2, BLG_PRVDR_SPCLTY_CD3, BLG_PRVDR_TXNMY_CD to carrier base file; RNDRNG_PRVDR_SPCLTY_CD1, RNDRNG_PRVDR_SPCLTY_CD2, RNDRNG_PRVDR_SPCLTY_CD3, RNDRNG_PRVDR_TXNMY_CD, LINE_POINT_OF_PCKP_ZIP_CD, and LINE_DROP_OFF_ZIP_CD to carrier line file. Added fields to additional files: CLM_ADMSN_DT to HHA and Hospice; CLM_CLNCL_TRIL_NUM to IP, SNF, HHA, Hospice and OP files; CLM_NEXT_GNRTN_ACO_IND_CD1–CLM_NEXT_GNRTN_ACO_IND_CD5 to DME line file. Added new values and descriptions for CLM_RLT_COND_CD, CLM_VAL_CD, DEMO_ID_NUM, AT_PHYSN_SPCLTY_CD, OP_PHYSN_SPCLTY_CD, OT_PHYSN_SPCLTY_CD, RFR_PHYSN_SPCLTY_CD, RNDRNG_PHYSN_SPCLTY_CD, LINE_PLACE_OF_SRVC_CD, CLM_NEXT_GNRTN_ACO_IND_CD1–CLM_NEXT_GNRTN_ACO_IND_CD5, PRVDR_NUM, and PRVDR_STATE_CD	1.11
August 2023	K. Schneider	Added comment re: small number of incorrect NCH_CLM_TYPE_CD values. Added new values and descriptions for CLM_PRCR_RTRN_CD, CLM_RLT_COND_CD, CLM_RLT_OCRNC_CD, CLM_SPAN_CD, CLM_VAL_CD, DMERC_OXGN_INITL_DT_CD, LINE_OTHR_APLD_IND_CD1-7, LINE_PLACE_OF_SRVC_CD, and PRVDR_NUM. Updated web link for MedPAC Payment Basic series, and web link for revenue center codes (REV_CNTR)	1.10

Date	Changed by	Revisions	Version
January 2023	K. Schneider	Added new fields and corresponding descriptions for: CLM_ADJUST_GRP_CD, CLM_ADJUST_RSN_CD, CLM_OP_PPS_IND, CLM_PRCR_VRSN_CD, DMERC_OXGN_EQUIP_INITL_DT, DMERC_OXGN_INITL_DT_CD, DMERC_OXGN_EQUIP_PRVS_DT, ESRD_TRTMT_CHS_IND_CD, LINE_ADJUST_GRP_CD, LINE_ADJUST_RSN_CD, LINE_RA_RMRK_CD, MS_DRG_GRPR_VRSN_CD, OWNG_PRVDR_TIN_NUM, PRVDR_FULL_CCN_NUM, REV_CNTR_ADJUST_GRP_CD, REV_CNTR_ADJUST_RSN_CD, REV_CNTR_RA_RMRK_CD, REV_CNTR_CRA_TPNIES_AMT, REV_CNTR_THRPY_RDCTN_AMT. Added values and corresponding descriptions for CARR_NUM, CLM_FREQ_CD, CLM_SRC_IP_ADMSN_CD, FI_NUM, REV_CNTR	1.9
April 2022	K. Schneider A. Sisco A. Meyer	Added values and corresponding descriptions for AT_PHYSN_SPCLTY_CD, OP_PHYSN_SPCLTY_CD, OT_PHYSN_SPCLTY_CD, RFR_PHYSN_SPCLTY_CD, RNDRNG_PHYSN_SPCLTY_CD, CLM_NEXT_GNRTN_ACO_IND_CD1- CLM_NEXT_GNRTN_ACO_IND_CD5, CLM_RLT_COND_CD, CLM_SRVC_CLSFCTN_TYPE_CD, DEMO_ID_NUM, LINE_OTHR_APLD_IND_CD1- LINE_OTHR_APLD_IND_CD7, REV_CNTR. Adjusted historical values and formatting for CARR_NUM and FI_NUM. Corrected values for CLM_VAL_CD, BENE_STATE_CD, DMERC_LINE_PRCNG_STATE_CD, and PRVDR_STATE_CD. Updated description for NCH_BENE_DSCHRG_DT and PRVDR_NUM.	1.8
February 2021	K. Schneider K. Russell C. Alleman	Migrated codebook to 2020 document template. Added four fields due to NCH version L updates: 1. LTCH_DSCHRG_PYMT_ADJSTMT_AMT to IP Base Claim; 2. ORDRG_PHYSN_NPI to hospice, HH and OP revenue lines; 3. RC_VLNTRY_SRVC_IND_CD to hospice, HH and OP revenue lines; 4. LINE_VLNTRY_SRVC_IND_CD to carrier and DME lines. Also changed CLM_DRG_CD from three to four characters, and LINE_OTHR_APLD_IND_CD1-LINE_OTHR_APLD_IND_CD7 from one to two characters	1.7
April 2020	S. Pietzsch	Added two fields to Part A layouts: CLM_MODEL_REIMBRSMT_AMT RC_MODEL_REIMBRSMT_AMT	1.6
September 2019	K. Schneider	Added values and corresponding descriptions for CLM_VAL_CD LINE_OTHR_APLD_IND_CD1–7, and provider specialty code (AT_PHYSN_SPCLTY_CD, OP_PHYSN_SPCLTY_CD, OT_PHYSN_SPCLTY_CD, RNDRNG_PHYSN_SPCLTY_CD, and RFR_PHYSN_SPCLTY_CD)	1.5

Date	Changed by	Revisions	Version
May 2019	C. Alleman K. Schneider	Added new fields: 1) CLM_RSDL_PYMT_IND_CD to all base claims, and LINE_RSDL_PYMT_IND_CD to carrier and DME lines; 2) CLM_RP_IND_CD to IP base claim, REV_CNTR_RP_IND_CD to SNF, HH, hospice and OP revenue lines, and LINE_RP_IND_CD to carrier and DME lines; 3) PRVDR_VLDTN_TYPE_CD to all base claims except for DME, and LINE_PRVDR_VLDTN_TYPE_CD to carrier and DME line; 4) RR_BRD_EXCLSN_IND_SW to IP,SNF, HH, hospice and OP base claims, and LINE_RR_BRD_EXCLSN_IND_SW to DME line; 5) CLM_IP_INITL_MS_DRG_CD to IP base file; and 6) DMERC_LINE_FRGN_ADR_IND to DME line. Also changed the name of the HHA base field FINL_STD_AMT to be PPS_STD_VAL_PYMT_AMT; edited description of FINL_STD_AMT and PPS_STD_VAL_PYMT_AMT.	1.4
January 2019	C. Alleman K. Schneider	Added new valid value for CLM_RLT_OCRNC_CD and new values for LINE_OTHR_APLD_IND_CD	1.3
August 2018	C. Alleman K. Schneider	Updated comments for variables: AT_PHYSN_SPCLTY_CD, CARR_LINE_ANSTHSA_UNIT_CNT, LINE_SRVC_CNT, TAX_NUM. Updated variable lengths: CARR_LINE_ANSTHSA_UNIT_CNT, LINE_SRVC_CNT. Updated values for LINE_PLACE_OF_SRVC_CD (values 02,18,19).	1.2
April 2018	C. Alleman	Updated TOC to sort on Long Name instead of Short Name.	1.1
February 2018	C. Alleman K. Schneider	Initial release of Codebook for Medicare Fee-For-Service Claims, Version K with CR13 updates.	1.0

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the Medicare fee-for-service (FFS) claims research files. We have included several ways for users to quickly find the information they need:

- A complete listing of all files' variables, in alphabetical order based on their SAS variable names.
- Individual entries for each variable contain a short description of the variable, the possible values for the variable, and, in many cases, comments discussing the variable construction and use.

We have included hyperlinks throughout the codebook to make it easier for users 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 individual variable page, 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

Variable Details

This section of the codebook contains one entry for each variable in the Medicare fee-for-service claims (version L) files. Each entry contains variable details to facilitate understanding and use of the variables.

ACO_ID_NUM

LABEL: Claim Accountable Care Organization (ACO) Identification Number

DESCRIPTION: The field identifies the Accountable Care Organization (ACO) Identification Number. This field populates the benefit enhancement indicators for all models, not just Next Generation ACOs.

SHORT NAME: ACO_ID_NUM

LONG NAME: ACO_ID_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: CMS began populating this field in 2016.

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ADMTG_DGNS_CD

LABEL: Claim Admitting Diagnosis Code

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

This diagnosis code after evaluating the patient; it may be different from the eventual diagnoses (e.g., as in PRNCPAL_DGNS_CD or ICD_DGNS_CD1–25).

SHORT NAME: ADMTG_DGNS_CD

LONG NAME: ADMTG_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: —

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ADMTG_DGNS_VRSN_CD

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

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

SHORT NAME: ADMTG_DGNS_VRSN_CD

LONG NAME: ADMTG_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

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AT_PHYSN_NPI

LABEL: Claim Attending Physician NPI Number

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

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

SHORT NAME: AT_NPI

LONG NAME: AT_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: —

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AT_PHYSN_SPCLTY_CD

LABEL: Claim Attending Physician Specialty Code

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

SHORT NAME: AT_PHYSN_SPCLTY_CD

LONG NAME: AT_PHYSN_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative medicine
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathologist in private practice
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistant (eff. 4/2003 — previously grouped with Certified Registered Nurse Anesthetists (CRNA))
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)

52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotic personnel certified by an accrediting organization
56 = Individual certified prosthetic personnel certified by an accrediting organization
57 = Individual certified prosthetic-orthotic personnel certified by an accrediting organization
58 = Medical supply company with registered pharmacist
59 = Ambulance service (private)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist in private practice
66 = Rheumatology
67 = Occupational therapist in private practice
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or Multispecialty clinic or group practice (PA Group)
71 = Registered Dietician/Nutrition Professional (eff. 1/2002)
72 = Pain Management (eff. 1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug stores)
88 = Unknown provider
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 7/2001/2006). Prior to 7/2001/2006, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecological/oncology
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = Skilled nursing facility (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)

A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2007)
B2 = Pedorthic Personnel (eff. 10/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery (MDS) (eff. 10/2020)
D8 = Adult Congenital Heart Disease
E1 = Marriage and Family Therapists
E2 = Mental Health Counselors
E3 = Dental Anesthesiology
E4 = Dental Public Health
E5 = Endodontics
E6 = Oral and Maxillofacial Pathology
E7 = Oral and Maxillofacial Radiology
E9 = Oral Medicine
F1 = Orofacial Pain
F2 = Orthodontics and Dentofacial Orthopedics
F3 = Pediatric Dentistry
F4 = Periodontics
F5 = Prosthodontics

COMMENT: CMS added this field to accommodate the Affordable Care Act (ACA) — for incentive payments to providers with specific primary care specialty designations. It was not populated before 2012. This field is not populated on inpatient or Skilled Nursing claims.

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AT_PHYSN_UPIN

LABEL: Claim Attending Physician UPIN Number

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

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

SHORT NAME: AT_UPIN

LONG NAME: AT_PHYSN_UPIN

TYPE: CHAR

LENGTH: 6

SOURCE: NCH

VALUES: —

COMMENT: —

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BENE_CNTY_CD

LABEL: County Code from Claim (SSA)

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

SHORT NAME: CNTY_CD

LONG NAME: BENE_CNTY_CD

TYPE: CHAR

LENGTH: 3

SOURCE: SSA/EDB

VALUES: —

COMMENT: The US Census website lists county codes. Also, CMS has core-based statistical area (CBSA) crosswalk files available on their website, which include state and county SSA codes.

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BENE_HOSPC_PRD_CNT

LABEL: Beneficiary's Hospice Period Count

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

Medicare covers hospice benefit periods, consisting of two initial 90-day periods followed by an unlimited number of 60-day periods.

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

SHORT NAME: HOSPCPRD

LONG NAME: BENE_HOSPC_PRD_CNT

TYPE: NUM

LENGTH: 1

SOURCE: NCH

VALUES: —

COMMENT: A series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” describe Medicare payments in detail. (reference: https://www.medpac.gov/document-type/payment-basic/)

Also, in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospice)

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BENE_ID

LABEL: Encrypted CCW Beneficiary ID

DESCRIPTION: The unique CCW identifier for a beneficiary.

The CCW assigns a unique beneficiary identification number to each individual who receives Medicare and/or Medicaid and uses that number to identify an individual's records in all CCW data files (e.g., Medicare claims, MAX claims, T-MSIS claims, and MDS assessment data).

This number does not change during a beneficiary's lifetime, and CCW uses each number only once.

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

SHORT NAME: BENE_ID

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

VALUES: —

COMMENT: —

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BENE_LRD_USED_CNT

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

DESCRIPTION: The number of lifetime reserve days that the beneficiary has elected to use during the period covered by the institutional claim.

Under Medicare, each beneficiary has a one-time reserve of sixty additional days of inpatient hospital coverage that the patient can use after 90 days of inpatient care have been provided in a single benefit period.

This count subtracts from the total number of lifetime reserve days that a beneficiary has available.

SHORT NAME: LRD_USE

LONG NAME: BENE_LRD_USED_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: —

COMMENT: —

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BENE_MLG_CNTCT_ZIP_CD

LABEL: ZIP Code of Residence from Claim

DESCRIPTION: The beneficiaries' mailing address ZIP code.

SHORT NAME: ZIP_CD

LONG NAME: BENE_MLG_CNTCT_ZIP_CD

TYPE: CHAR

LENGTH: 9

SOURCE: EDB

VALUES: —

COMMENT: —

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BENE_RACE_CD

LABEL: Beneficiary Race Code

DESCRIPTION: Race code from claim

SHORT NAME: RACE_CD

LONG NAME: BENE_RACE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: SSA

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

COMMENT: —

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BENE_STATE_CD

LABEL: Beneficiary Residence (SSA) State Code

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

SHORT NAME: STATE_CD

LONG NAME: BENE_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: SSA/EDB

VALUES:

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada and Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
97 = Northern Marianas

98 = Guam

99 = Unknown or if county code = 000 then this is American Samoa

COMMENT: —

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BENE_TOT_COINSRNC_DAYS_CNT

LABEL: Beneficiary Total Coinsurance Days Count

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

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

Different rules apply for lifetime reserve days, etc.

SHORT NAME: COIN_DAY

LONG NAME: BENE_TOT_COINSRNC_DAYS_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: —

COMMENT: —

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BETOS_CD

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

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

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

SHORT NAME: BETOS

LONG NAME: BETOS_CD

TYPE: CHAR

LENGTH: 3

SOURCE: NCH

VALUES:

D1A = Medical/Surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Prosthetic/Orthotic devices
D1G = Drugs Administered through DME
I1A = Standard imaging — chest
I1B = Standard imaging — musculoskeletal
I1C = Standard imaging — breast
I1D = Standard imaging — contrast gastrointestinal
I1E = Standard imaging — nuclear medicine
I1F = Standard imaging — other
I2A = Advanced imaging — CAT/CT/CTA: brain/head/neck
I2B = Advanced imaging — CAT/CT/CTA: other
I2C = Advanced imaging — MRI/MRA: brain/head/neck
I2D = Advanced imaging — MRI/MRA: other
I3A = Echography/ultrasonography — eye
I3B = Echography/ultrasonography — abdomen/pelvis
I3C = Echography/ultrasonography — heart
I3D = Echography/ultrasonography — carotid arteries
I3E = Echography/ultrasonography — prostate, transrectal
I3F = Echography/ultrasonography — other
I4A = Imaging/procedure — heart including cardiac catheterization
I4B = Imaging/procedure — other
M1A = Office visits — new
M1B = Office visits — established
M2A = Hospital visit — initial
M2B = Hospital visit — subsequent
M2C = Hospital visit — critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist — pathology
M5B = Specialist — psychiatry
M5C = Specialist — ophthalmology
M5D = Specialist — other
M6 = Consultations
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Hearing and speech services
O1G = Immunizations/Vaccinations
P0 = Anesthesia
P1A = Major procedure — breast

P1B = Major procedure — colectomy
P1C = Major procedure — cholecystectomy
P1D = Major procedure — turp
P1E = Major procedure — hysterectomy
P1F = Major procedure — explor/decompr/excisdisc
P1G = Major procedure — Other
P2A = Major procedure, cardiovascular—CABG
P2B = Major procedure, cardiovascular—Aneurysm repair
P2C = Major procedure, cardiovascular — Thromboendarterectomy
P2D = Major procedure, cardiovascular — Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular — Pacemaker insertion
P2F = Major procedure, cardiovascular — Other
P3A = Major procedure, orthopedic — Hip fracture repair
P3B = Major procedure, orthopedic — Hip replacement
P3C = Major procedure, orthopedic — Knee replacement
P3D = Major procedure, orthopedic — other
P4A = Eye procedure — corneal transplant
P4B = Eye procedure — cataract removal/lens insertion
P4C = Eye procedure — retinal detachment
P4D = Eye procedure — treatment of retinal lesions
P4E = Eye procedure — other
P5A = Ambulatory procedures — skin
P5B = Ambulatory procedures — musculoskeletal
P5C = Ambulatory procedures — inguinal hernia repair
P5D = Ambulatory procedures — lithotripsy
P5E = Ambulatory procedures — other
P6A = Minor procedures — skin
P6B = Minor procedures — musculoskeletal
P6C = Minor procedures — other (Medicare fee schedule)
P6D = Minor procedures — other (non-Medicare fee schedule)
P7A = Oncology — radiation therapy
P7B = Oncology — other
P8A = Endoscopy — arthroscopy
P8B = Endoscopy — upper gastrointestinal
P8C = Endoscopy — sigmoidoscopy
P8D = Endoscopy — colonoscopy
P8E = Endoscopy — cystoscopy
P8F = Endoscopy — bronchoscopy
P8G = Endoscopy — laparoscopic cholecystectomy
P8H = Endoscopy — laryngoscopy
P8I = Endoscopy — other
P9A = Dialysis services (Medicare fee schedule)
P9B = Dialysis services (non-Medicare fee schedule)
T1A = Lab tests — routine venipuncture (non-Medicare fee schedule)
T1B = Lab tests — automated general profiles
T1C = Lab tests — urinalysis
T1D = Lab tests — blood counts
T1E = Lab tests — glucose
T1F = Lab tests — bacterial cultures
T1G = Lab tests — other (Medicare fee schedule)
T1H = Lab tests — other (non-Medicare fee schedule)
T2A = Other tests — electrocardiograms
T2B = Other tests — cardiovascular stress tests
T2C = Other tests — EKG monitoring
T2D = Other tests — other
Y1 = Other — Medicare fee schedule
Y2 = Other — non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

COMMENT: CMS derives this field using a Healthcare Common Procedure Coding System (HCPCS) code to BETOS code crosswalk.

^ Back to TOC ^

BLG_PRVDR_SPCLTY_CD1

BLG_PRVDR_SPCLTY_CD2

BLG_PRVDR_SPCLTY_CD3

LABEL: Claim Billing Provider Secondary Specialty Code (1–3)

DESCRIPTION: The CMS secondary specialty code(s) assigned to the billing provider's National Provider Identifier (NPI). These specialty codes apply to the carrier claim billing NPI number (CARR_CLM_BLG_NPI_NUM).

SHORT NAME: BLG_PRVDR_SPCLTY_CD1
BLG_PRVDR_SPCLTY_CD2
BLG_PRVDR_SPCLTY_CD3

LONG NAME: BLG_PRVDR_SPCLTY_CD1
BLG_PRVDR_SPCLTY_CD2
BLG_PRVDR_SPCLTY_CD3

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathology
16 = Obstetrics/gynecology
17 = Hospice and palliative care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = General psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistants (eff. 4/2003 — previously grouped with Certified Registered Nurse Anesthetists [CRNA])
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometrist
42 = Certified nurse midwife

43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist assistants were removed from this specialty 4/1/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
47 = Independent diagnostic testing facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Medical supply company with registered pharmacist
59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (private practice added 4/1/2003) (independently practicing removed 4/1/2003)
66 = Rheumatology
67 = Occupational therapist (private practice added 4/1/2003) (independently practicing removed 4/1/2003)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or multispecialty clinic or group practice
71 = Registered dietician/Nutrition professional (eff. 1/2002)
72 = Pain management (eff. 1/2002)
73 = Mass immunization roster biller
74 = Radiation therapy centers (prior to 4/2003 this included independent diagnostic testing facilities (IDTF)
75 = Slide preparation facilities (added to differentiate them from independent diagnostic testing facilities (IDTFs — eff. 4/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/Oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug and department stores)
88 = Unknown supplier/Provider specialty
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology

95 = Competitive Acquisition Program (CAP) vendor (eff. 7/2001/2006) Prior to 07/2001/2006, known as independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecologist/oncologist
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = SNF (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2007)
B2 = Pedorthic Personnel (eff. 10/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2007)
B4 = Does not meet definition of health care provider (e.g., rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and hyperbaric medicine
D5 = Opioid treatment program (eff. 1/2020)
D7 = Micrographic dermatologic surgery
D8 = Adult congenital heart disease
E1 = Marriage and family therapists
E2 = Mental health counselors
E3 = Dental anesthesiology
E4 = Dental public health
E5 = Endodontics
E6 = Oral and maxillofacial pathology
E7 = Oral and maxillofacial radiology
E9 = Oral medicine
F1 = Orofacial pain
F2 = Orthodontics and dentofacial orthopedics
F3 = Pediatric dentistry
F4 = Periodontics
F5 = Prosthodontics

COMMENT: These fields are added to the data file October 2023. The primary specialty code for the rendering provider is “LINE_HCFA_PRVDR_SPCLTY_CD.” These codes are all secondary-specialty codes — not primary specialty codes, just additional specialties that the provider has.

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BLG_PRVDR_TXNMY_CD

LABEL: Claim Billing Provider Taxonomy Code

DESCRIPTION: The taxonomy code assigned to the billing provider’s National Provider Identifier (NPI). A taxonomy code is a unique 10-character code that assigns a provider's classification and specialization. Providers use this code when applying for a National Provider Identifier (NPI).This taxonomy code applies to the carrier claim billing NPI number (CARR_CLM_BLG_NPI_NUM).

SHORT NAME: BLG_PRVDR_TXNMY_CD

LONG NAME: BLG_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field was added to the data file October 2023.

This code set is an external code set maintained by the National Uniform Claim Committee (NUCC) (https://www.nucc.org/index.php).

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CARR_CLM_BLG_NPI_NUM

LABEL: Carrier Claim Billing NPI Number

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

SHORT NAME: CARR_CLM_BLG_NPI_NUM

LONG NAME: CARR_CLM_BLG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: —

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CARR_CLM_CASH_DDCTBL_APLD_AMT

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

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

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

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

SHORT NAME: DEDAPPLY

LONG NAME: CARR_CLM_CASH_DDCTBL_APLD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: The Medicare.gov website describes beneficiaries' costs in detail. There is a CMS publication called "Your Medicare Benefits," which explains the deductibles.

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CARR_CLM_ENTRY_CD

LABEL: Carrier Claim Entry Code

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

SHORT NAME: ENTRY_CD

LONG NAME: CARR_CLM_ENTRY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

^ Back to TOC ^

CARR_CLM_HCPCS_YR_CD

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

DESCRIPTION: The Healthcare Common Procedure Coding System (HCPCS) uses this terminal digit to code the claim.

SHORT NAME: HCPCS_YR

LONG NAME: CARR_CLM_HCPCS_YR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

^ Back to TOC ^

CARR_CLM_PMT_DNL_CD

LABEL: Carrier Claim Payment Denial Code

DESCRIPTION: The code on a non-institutional claim indicating who receives payment or if the claim was denied.

SHORT NAME: PMTDNLCD

LONG NAME: CARR_CLM_PMT_DNL_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: Only one-byte was used until 1/2011 (currently, either 1- or 2-byte values may be used, symbols not currently allowed)

0 = Denied
1 = Physician/Supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital-based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g., Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of liability
B = Physician/Supplier under limitation of liability
D = Denied due to demonstration involvement
E = MSP cost avoided IRS/SSA/HCFA data match (after 01/2001 is first claim development)
F = MSP cost avoided HMO rate cell (after 1/2001 is trauma code development)
G = MSP cost avoided litigation settlement (after 1/2001 is secondary claims investigation)
H = MSP cost avoided employer voluntary reporting (after 1/2001 is self-reports)
J = MSP cost avoided insurer voluntary reporting (eff. 7/2000)
K = MSP cost avoided initial enrollment questionnaire (eff. 7/2000)
P = Physician ownership denial
Q = MSP cost avoided — voluntary agreements including with employer
T = MSP cost avoided — initial enrollment questionnaire
U = MSP cost avoided — HMO rate cell adjustment
V = MSP cost avoided — litigation settlement
X = MSP cost avoided — generic
Y = MSP cost avoided — IRS/SSA data match
00 = MSP cost avoided — COB contractor
12 = MSP cost avoided — BC/BS voluntary data sharing agreements (VDSA)
13 = MSP cost avoided — Office of Personnel Management (OPM) data match
14 = MSP cost avoided — workman's compensation (WC) data match
15 = MSP cost avoided — workman's compensation insurer voluntary data sharing agreements (WC VDSA)
16 = MSP cost avoided — liability insurer VDSA
17 = MSP cost avoided — no-fault insurer VDSA

18 = MSP cost avoided — pharmacy benefit manager data sharing agreement
19 = MSP cost avoided — worker's compensation Medicare set-aside arrangement (eff. 4/2006)
21 = MSP cost avoided — MIR group health plan
22 = MSP cost avoided — MIR non-group health plan
25 = MSP cost avoided — recovery audit contractor — California
26 = MSP cost avoided — recovery audit contractor — Florida
41 = MSP cost avoided — non-group health plan non-ongoing responsibility for medical (ORM)
43 = MSP cost avoided — Medicare Part C/Medicare Advantage

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

! = MSP cost avoided — COB contractor (converted to "00" 2-byte code)

@ = MSP cost avoided — BC/BS voluntary agreements (converted to "12" 2-byte code)

= MSP cost avoided — Office of Personnel Management (converted to "13" 2-byte code)

$ = MSP cost avoided — workman's compensation (WC) data match (converted to "14" 2-byte code)

* = MSP cost avoided — workman's compensation insurer voluntary data sharing agreements (WC VDSA) (eff. 4/2006) (converted to "15" 2-byte code)

(= MSP cost avoided — liability insurer VDSA (eff. 4/2006) (converted to "16" 2-byte code)

) = MSP cost avoided — no-fault insurer VDSA (eff. 4/2006) (converted to "17" 2-byte code)

+ = MSP cost avoided — pharmacy benefit manager data sharing agreement (eff. 4/2006) (converted to "18" 2-byte code)

< = MSP cost avoided — MIR group health plan (eff. 1/2009) (converted to "21" 2-byte code)

> = MSP cost avoided — MIR non-group health plan (eff. 1/2009) (converted to "22" 2-byte code)

% = MSP cost avoided — recovery audit contractor — California (eff. 10/2005) (converted to "25" 2-byte code)

& = MSP cost avoided — recovery audit contractor — Florida (eff. 10/2005) (converted to "26" 2-byte code)

COMMENT: Effective with version "J," the field was expanded on the NCH record to 2 bytes, with his expansion, the NCH will no longer use the character values to represent the official two-byte values sent in by NCH since 4/2002. During the version J conversion, all character values were converted to the two-byte values.

On 4/1/2002, this field was expanded to two bytes to accommodate new values. The NCH nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value.

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CARR_CLM_PRVDR_ASGNMT_IND_SW

LABEL: Carrier Claim Provider Assignment Indicator Switch

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

SHORT NAME: ASGMNTCD

LONG NAME: CARR_CLM_PRVDR_ASGNMT_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

^ Back to TOC ^

CARR_CLM_RFRNG_PIN_NUM

LABEL: Carrier Claim Referring Provider ID Number (PIN)

DESCRIPTION: The provider identification number (PIN) of the physician/supplier (assigned by the MAC) who referred the beneficiary to the physician who ordered these services.

SHORT NAME: RFR_PRFL

LONG NAME: CARR_CLM_RFRNG_PIN_NUM

TYPE: CHAR

LENGTH: 14

SOURCE: NCH

VALUES: —

COMMENT: CMS identifies providers using the National Provider Identifier (NPI; eff. 5/2007), which replaces legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

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CARR_CLM_SOS_NPI_NUM

LABEL: Carrier Claim Site of Service NPI Number

DESCRIPTION: This field identifies the site of service National Provider Identifier (NPI).

SHORT NAME: CARR_CLM_SOS_NPI_NUM

LONG NAME: CARR_CLM_SOS_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated prior to 2009.

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CARR_LINE_ANSTHSA_UNIT_CNT

LABEL: Carrier Line Anesthesia Unit Count

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

SHORT NAME: CARR_LINE_ANSTHSA_UNIT_CNT

LONG NAME: CARR_LINE_ANSTHSA_UNIT_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field may have decimals (it is formatted as SAS length 11.3). Prior to version "J," this field was S9(3), length 7.3.

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CARR_LINE_CL_CHRG_AMT

LABEL: Carrier Line Clinical Lab Charge Amount

DESCRIPTION: Clinical lab charge amount on the carrier line.

SHORT NAME: CARR_LINE_CL_CHRG_AMT

LONG NAME: CARR_LINE_CL_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CARR_LINE_CLIA_LAB_NUM

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

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

SHORT NAME: CARR_LINE_CLIA_LAB_NUM

LONG NAME: CARR_LINE_CLIA_LAB_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: —

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CARR_LINE_MDPP_NPI_NUM

LABEL: Carrier Line Medicare Diabetes Prevention Program (MDPP) NPI Number

DESCRIPTION: This field represents the National Provider Identifier (NPI) of the Medicare Diabetes Prevention Program (MDPP) coach.

SHORT NAME: CARR_LINE_MDPP_NPI_NUM

LONG NAME: CARR_LINE_MDPP_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is new in April 2018.

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CARR_LINE_MTUS_CD

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

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

SHORT NAME: MTUS_IND

LONG NAME: CARR_LINE_MTUS_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

^ Back to TOC ^

CARR_LINE_MTUS_CNT

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

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

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

SHORT NAME: MTUS_CNT

LONG NAME: CARR_LINE_MTUS_CNT

TYPE: NUM

LENGTH: 11

SOURCE: NCH

VALUES: —

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

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CARR_LINE_PRCNG_LCLTY_CD

LABEL: Carrier Line Pricing Locality Code

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

SHORT NAME: LCLTY_CD

LONG NAME: CARR_LINE_PRCNG_LCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: Medicare localities

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

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

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

1 =	ALABAMA	24 =	IDAHO
2 =	ALASKA	25 =	CHICAGO, IL
3 =	ARIZONA	26 =	EAST ST. LOUIS, IL
4 =	ARKANSAS	27 =	REST OF ILLINOIS
5 =	ANAHEIM/SANTA ANA, CA	28 =	SUBURBAN CHICAGO, IL
6 =	LOS ANGELES, CA	29 =	INDIANA
7 =	MARIN/NAPA/SOLANO, CA	30 =	IOWA
8 =	OAKLAND/BERKELEY, CA	31 =	KANSAS
9 =	REST OF CALIFORNIA	32 =	KENTUCKY
10 =	SAN FRANCISCO, CA	33 =	NEW ORLEANS, LA
11 =	SAN MATEO, CA	34 =	REST OF LOUISIANA
12 =	SANTA CLARA, CA	35 =	REST OF MAINE
13 =	VENTURA, CA	36 =	SOUTHERN MAINE
14 =	COLORADO	37 =	BALTIMORE/SURR. CNTYS, MD
15 =	CONNECTICUT	38 =	REST OF MARYLAND
16 =	DC + MD/VA SUBURBS	39 =	METROPOLITAN BOSTON
17 =	DELAWARE	40 =	REST OF MASSACHUSETTS
18 =	FORT LAUDERDALE, FL	41 =	DETROIT, MI
19 =	MIAMI, FL	42 =	REST OF MICHIGAN
20 =	REST OF FLORIDA	43 =	MINNESOTA
21 =	ATLANTA, GA	44 =	MISSISSIPPI
22 =	REST OF GEORGIA	45 =	METROPOLITAN KANSAS CITY, MO
23 =	HAWAII	46 =	METROPOLITAN ST. LOUIS, MO

47 = REST OF MISSOURI
48 = MONTANA
49 = NEBRASKA
50 = NEVADA
51 = NEW HAMPSHIRE
52 = NORTHERN NJ
53 = REST OF NEW JERSEY
54 = NEW MEXICO
55 = MANHATTAN, NY
56 = NYC SUBURBS/LONG I., NY
57 = POUGHKPSIE/N NYC SUBURBS, NY
58 = QUEENS, NY
59 = REST OF NEW YORK
60 = NORTH CAROLINA
61 = NORTH DAKOTA
62 = OHIO
63 = OKLAHOMA
64 = PORTLAND, OR
65 = REST OF OREGON
66 = METROPOLITAN PHILADELPHIA, PA
67 = REST OF PENNSYLVANIA
68 = PUERTO RICO
69 = RHODE ISLAND
70 = SOUTH CAROLINA
71 = SOUTH DAKOTA
72 = TENNESSEE
73 = AUSTIN, TX
74 = BEAUMONT, TX
75 = BRAZORIA, TX
76 = DALLAS, TX
77 = FORT WORTH, TX
78 = GALVESTON, TX
79 = HOUSTON, TX
80 = REST OF TEXAS
81 = UTAH
82 = VERMONT
83 = VIRGIN ISLANDS
84 = VIRGINIA
85 = REST OF WASHINGTON
86 = SEATTLE (KING CNTY), WA
87 = WEST VIRGINIA
88 = WISCONSIN
89 WYOMING

Locality codes = 0, A1, A2, A3, A4, A5, A6, A7, B1, B2, B4, B5, B6, B7, B8, C1, C2, C3, C5, C7, C8, D2, D5, D6, D8, E1, E3, E5, E7, F2, F6, F7, F8, G1, G2, G3, G5, G6, G7, G8, G9, H4, H5, H8, H9, J2, J3, J4, J6, J7, and K4.

COMMENT: Carrier pricing locality isn't maintained by CWF and CMS. Each MAC sets up their locality values that would be sent to CWF.

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CARR_LINE_PRVDR_TYPE_CD

LABEL: Carrier Line Provider Type Code

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

SHORT NAME: PRV_TYPE

LONG NAME: CARR_LINE_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: For Physician/Supplier Claims:

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

COMMENT: Prior to version H, DME claims also used this code; the following were valid codes:

0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned

1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field

2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown

3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field

4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown

5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field

6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown

7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field

8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field

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CARR_LINE_RDCD_PMT_PHYS_ASTN_C

LABEL: Carrier Line Reduced Payment Physician Assistant Code

DESCRIPTION: The code on the carrier (non-DMERC) line item that identifies the line items that have been paid a reduced fee schedule amount (65%, 75%, or 85%) because a physician's assistant performed the service.

SHORT NAME: ASTNT_CD

LONG NAME: CARR_LINE_RDCD_PMT_PHYS_ASTN_C

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: BLANK = Adjustment situation (where CLM_DISP_CD equal 3)
0 = N/A
1 = 65% of payment. Either physician assistants assisting in surgery or nurse midwives
2 = 75% of payment. Either physician assistants performing services in a hospital (other than assisting surgery) or nurse practitioners/clinical nurse specialist performing services in rural areas or clinical social worker services
3 = 85% of payment. Either physician assistant services for other than assisting surgery or other hospital services or nurse practitioners' services (not in rural areas)

COMMENT: —

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CARR_LINE_RX_NUM

LABEL: Carrier Line RX Number

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

SHORT NAME: CARRXNUM

LONG NAME: CARR_LINE_RX_NUM

TYPE: CHAR

LENGTH: 30

SOURCE: NCH

VALUES: —

COMMENT: The prescription order number consists of:

- Vendor ID number (positions 1–4)
- HCPCS code (positions 5–9)
- Vendor controlled prescription number (positions 10–30)

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

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CARR_NUM

LABEL: Carrier or MAC Number

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

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

SHORT NAME: CARR_NUM

LONG NAME: CARR_NUM

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES:
00510 = Alabama — CAHABA (eff. 1983; term. 05/2009)
00511 = Georgia — CAHABA (eff. 1998; term. 06/2009) (replaced by MAC #10202)
00512 = Mississippi — CAHABA (eff. 2000)
00520 = Arkansas BC/BS (eff. 1983)
00521 = New Mexico — Arkansas BC/BS (eff. 1998; term. 02/2008) (replaced by MAC #04202)
00522 = Oklahoma — Arkansas BC/BS (eff. 1998; term. 02/2008) (replaced by MAC #04302)
00523 = Missouri East — Arkansas BC/BS (eff. 1999; term. 02/2008) (replaced by MAC #05392)
00524 = Rhode Island — Arkansas BC/BS (eff. 2004; term. 01/2009) (replaced by MAC #14402)
00528 = Louisiana — Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 05/2009)
00590 = Florida — First Coast (eff. 1983; term. 01/2009) (replaced by MAC #09102)
00591 = Connecticut — First Coast (eff. 2000; term. 07/2008) (replaced by MAC #13102)
00630 = Indiana — Administer (eff. 1983) (term. 08/2012) (replaced by MAC #08102)
00635 = DMERC-B — Administer (eff. 1993; term. 06/2006) (replaced by MAC #17003)
00650 = Kansas BCBS (eff. 1983; term. 02/2008) (replaced by MAC #05202)
00651 = Missouri — Kansas BCBS (eff. 1983; term. 02/2008) (replaced by MAC #05202)
00655 = Nebraska — Kansas BC/BS (eff. 1988; term. 02/2008) (replaced by MAC #05402)
00660 = Kentucky — Administer (eff. 1983; term. 04/2011)
00663 = FQHC Pilot Demo (CAFM — Ayers-Ramsey) (term. 11/2011)
00710 = Michigan BS (eff. 1983; term. 09/2000)
00720 = Minnesota BS (eff. 1983; term. 09/2000)
00740 = Western Missouri — Kansas BS (eff. 1983; term. 06/1997) (replaced by MAC #05302)
00751 = Montana BC/BS (eff. 1983; term. 11/2006) (replaced by MAC # 03202)
00801 = New York — Health now (eff. 1983; term. 08/2008) (replaced by MAC #13282)
00803 = New York — Empire BS (eff. 1983; term. 07/2008) (replaced by MAC #13202)
00804 = New York — Rochester BS (term. 02/1999) (replaced by MAC # 12402)
00805 = New Jersey — Empire BS (eff. 3/99; term. 11/2008) (replaced by MAC # 12402)
00811 = DMERC (A) — Health now (eff. 2000; term. 06/2006) (replaced by MAC #16003)
00820 = North Dakota — Noridian (eff. 1983; term. 11/2006) (replaced by MAC #03302)

00823 = Utah — Noridian (eff. 12/1/2005; term. 11/2006) (replaced by MAC #03502)
00824 = Colorado — Noridian (eff. 1995; term. 02/2008) (replaced by MAC #04102)
00825 = Wyoming — Noridian (eff. 1990; term. 11/2006) (replaced by MAC #03602)
00826 = Iowa — Noridian (eff. 1999; term. 01/2008) (replaced by MAC #05102)
00831 = Alaska — Noridian (eff. 1998)
00832 = Arizona — Noridian (eff. 1998; term. 11/2006) (replaced by MAC # 03102)
00833 = Hawaii — Noridian (eff. 1998; term. 07/2008) (replaced by MAC # 01202)
00834 = Nevada — Noridian (eff. 1998; term. 07/2008) (replaced by MAC # 01302)
00835 = Oregon — Noridian (eff. 1998)
00836 = Washington — Noridian (eff. 1998)
00865 = Pennsylvania — Highmark (eff. 1983; term. 12/2008) (replaced by MAC # 12502)
00870 = Rhode Island BS (eff. 1983; term. 02/1999)
00880 = South Carolina — Palmetto (eff. 1983; term. 06/2011)
00882 = RRB — South Carolina PGBA (eff. 2000)
00883 = Ohio — Palmetto (eff. 2002; term. 06/2011)
00884 = West Virginia — Palmetto (eff. 2002; term. 06/2011)
00885 = DMERC C — Palmetto (eff. 1993; term. 05/2006) (replaced by MAC #18003)
00889 = South Dakota — Noridian (eff. 4/1/2006; term. 11/2006) (replaced by MAC # 03402)
00900 = Texas — Trailblazer (eff. 1983; term. 06/2008) (replaced by MAC # 04402)
00901 = Maryland — Trailblazer (eff. 1995; term. 07/2008) (replaced by MAC # 12302)
00902 = Delaware — Trailblazer (eff. 1998; term. 07/2008) (replaced by MAC # 12102)
00903 = District of Columbia — Trailblazer (eff. 1998; term. 07/2008) (replaced by MAC # 12202)
00904 = Virginia — Trailblazer (eff. 2000; term. 03/2011) (replaced by MAC # 11302)
00910 = Utah BS (eff. 1983; term. 09/2006)
00951 = Wisconsin — Wisconsin Phy Svc (eff. 1983)
00952 = Illinois — Wisconsin Phy Svc (eff. 1999)
00953 = Michigan — Wisconsin Phy Svc (eff. 1999; term. 07/15/2012) (replaced by MAC #08202)
00954 = Minnesota — Wisconsin Phy Svc (eff. 2000)
00960 = WPS Part D GAP (CAFM) (Truffer) (eff. 01/2010)
00973 = Puerto Rico — Triple S, Inc. (eff. 1983; term. 02/2009) (replaced by MAC # 09302)
00974 = Triple-S, Inc. — Virgin Islands (term. 02/2009)
01002 = J1 Roll-up
01102 = California (eff. 9/1/08) (replaces carrier #00832)
1112 = California, Northern — Noridian Healthcare Solutions
11182 = California, Southern — Noridian Healthcare Solutions
01192 = Palmetto GBA J1 (S CA) (eff. 09/2001/2008)
01202 = Hawaii (eff. 8/1/08) (replaces carrier #00833)
1212 = American Samoa. Guam, Hawaii, Northern Mariana Islands — Noridian Healthcare Solutions
01302 = Nevada (eff. 8/1/08) (replaces carrier #00834)
1312 = Nevada — Noridian Healthcare Solutions
01380 = Oregon — AETNA (eff. 1983; term. 09/2000)
01390 = Washington — AETNA (eff. 1994; term. 09/2000)
02002 = JF Roll-up (2/3)
02050 = California — TOLIC (eff. 1983; term. 09/1991)
02102 = Alaska — Noridian Admin Svcs (eff. 02/2001/2012)
02202 = Idaho — Noridian Admin Svcs (eff. 02/2001/2012)
02302 = Oregon — Noridian Admin Svcs (eff. 02/2001/2012)
02402 = Washington — Noridian Admin Svcs (eff. 02/2001/2012)

02831 = WEST.CONSORT.OCCIDENTAL — ALASKA (term. 07/2002)
02832 = WEST.CONSORT.OCCIDENTAL — ALASKA (term. 07/2002)
02833 = WEST.CONSORT.OCCIDENTAL — ALASKA
02835 = WEST.CONSORT.OCCIDENTAL — ALASKA
03002 = JF Roll-up (2/3) (orig. J3)
03102 = Arizona (eff. 12/1/2006) (replaces carrier #00832)
03202 = Montana (eff. 12/1/2006) (replaces carrier #00751)
03302 = N. Dakota (eff. 12/1/2006) (replaces carrier #00820)
03402 = S. Dakota (eff. 12/1/2006) (replaces carrier #00889)
03502 = Utah (eff. 12/1/2006) (replaces carrier #00823)
03602 = Wyoming (eff. 12/1/2006) (replaces carrier #00825)
04002 = J4 Roll-up
04102 = Colorado (eff. 3/24/08; term.) (replaces carrier #00550)
04112 = Colorado — Novitas Solutions JH (eff. 11/17/2012)
04202 = New Mexico (eff. 3/1/08 (replaces carrier #00521)
04212 = New Mexico — Novitas Solutions JH (eff. 11/17/2012)
04302 = Oklahoma (eff. 3/1/08) (replaces carrier #00522)
04312 = Oklahoma — Novitas Solutions JH (eff. 11/17/2012)
04402 = Texas (eff. 6/2001/08) (replaces carrier #00900)
04412 = Texas — Novitas Solutions JH (eff. 11/17/2012)
05002 = J5 Roll-up
05102 = Iowa (eff.2/1/08) (replaces carrier #00826)
05130 = Idaho — CIGNA (eff. 1983)
05202 = Kansas (eff. 3/1/08) (replaces carrier #00650)
05302 = W. Missouri (eff. 3/1/08) (replaces carrier #00651 or 00740)
05330 = NEW YORK — Equitable
05392 = E. Missouri (eff. 6/1/08) (replaces carrier #00523)
05402 = Nebraska (eff. 3/1/08) (replaces carrier #00655)
05440 = Tennessee — CIGNA (eff. 1983; term. 08/2009) (replaced by MAC #10302)
05535 = North Carolina — CIGNA (eff. 1988)
05655 = DMERC-D Alaska — CIGNA (eff. 1993; term. 09/2006) (replaced by MAC #19003)
06002 = J6 Roll-up
06102 = Illinois
06140 = Illinois — Continental Casualty (term. 11/2008)
06202 = Minnesota
06302 = Wisconsin
07002 = JH Roll-up (4/7)
07102 = Arkansas — Novitas Solutions JH (eff. 08/11/2012) (CR7812)
07180 = Kentucky — Metropolitan (term. 11/2000)
07202 = Louisiana — Novitas Solutions JH (eff. 08/11/2012)
07302 = Mississippi — Novitas Solutions JH (eff. 10/20/2012)
08002 = J8 Roll-up
08102 = Indiana (eff. 8/20/2012) (replaces carrier #00630)
08190 = Louisiana — Pan American10070 = RRB — UnitedHealthcare (term. 02/2004)
08202 = Michigan (eff. 7/16/2012) (replaces carrier #00953)
09002 = J9 Roll-up
09102 = Florida — First Coast (eff. 02/2009) (replaces carrier #00590)
09202 = Puerto Rico — First Coast (eff. 03/2009) (replaces carrier #00973)

09302 = Virgin Island — First Coast (eff. 03/2009) (replaces carrier #00974)
10002 = J10 Roll-up
10071 = RRB — United Healthcare (term. 2000)
10072 = RRB — United Healthcare (term.)
10074 = RRB — United Healthcare (term. 09/2000)
10102 = Alabama (eff. 5/4/09) (replaces carrier #00510)
10112 =Alabama, statewide, all counties — Palmetto GBA
10202 = Georgia (eff. 8/3/09) (replaces carrier #00511)
10212 = Georgia, Atlanta and rest of state — Palmetto GBA
10230 = Connecticut — Metra Health (eff. 1986; term. 2000)
10240 = Minnesota — Metra Health (eff. 1983; term. 08/1994)
10250 = Mississippi — Metra Health (eff. 1983; term. 09/2000)
10302 = Tennessee (eff. 9/1/09) (replaces carrier #05440)
10312 = Tennessee, statewide, all counties — Palmetto GBA
10490 = Virginia — Metra Health (eff. 1983; term. 05/1997)
10555 = DMERC A — United Healthcare (eff. 1993; term. 12/1993)
11002 = J11 Roll-up
11202 = South Carolina — Palmetto Gov. Benefits Admin. (PGBA)
11302 = Virginia (eff. 3/19/2011) Palmetto Gov. Benefits Admin. (PGBA) (replaces carrier #00904)
11402 = West Virginia (eff. 6/18/2011) Palmetto Gov. Benefits Admin. (PGBA)
11502 = North Carolina (eff. 5/28/2011) Palmetto Gov. Benefits Admin. (PGBA)
12002 = J12 Roll-up
12102 = Delaware (eff. 7/11/2008) (replaces carrier #00902)
12202 = District of Columbia (eff. 7/11/2008) (replaces carrier #00903) NOTE: Includes Montgomery & Prince Georges Counties in Maryland; and Fairfax County and the City of Alexandria, VA
12302 = Maryland (eff. 7/11/2008) (replaces carrier #00901)
12402 = New Jersey (eff. 11/14/2008) (replaces carrier #00805)
12502 = Pennsylvania (eff. 12/12/2008) (replaces carrier #00865)
13002 = J13 Roll-up
13102 = Connecticut (eff. 8/1/2008) (replaces carrier #00591)
13202 = East New York (eff. 7/18/2008) (replaces carrier #00803)
13282 = West New York (eff. 9/1/2008) (replaces carrier #00801)
13292 = New York (Queens) (eff. 7/18/2008) (replaces carrier #14330)
14002 = J14 Roll-up
14102 = Maine (eff. 6/1/2009) (replaces carrier #31142)
14112 = Maine, southern Maine and rest of state — National Government Services, Inc.
14202 = Massachusetts (eff. 6/1/2009) (replaces carrier #31143)
14212 = Massachusetts, metro Boston and rest of state — National Government Services, Inc.
14302 = N. Hampshire (eff. 6/1/2009) (replaces carrier #31144)
14312 = New Hampshire, statewide — National Government Services, Inc.
14330 = New York — GHI (eff. 1983; term. 07/2008) (replaced by MAC #13292)
14402 = Rhode Island (eff. 5/1/2009) (replaces carrier #00524)
14412 = Rhode Island, statewide — National Government Services, Inc.
14502 = Vermont (eff. 6/1/2009) (replaces carrier #31145)
14512 = Vermont, statewide — National Government Services, Inc.
15002 = J15 Roll-up
15102 = Kentucky (eff. 4/30/2011) CGS Government Services
15202 = Ohio (eff. 06/15/2011) CGS Government Services

16003 = National Heritage Insurance Company (NHIC) (A) (eff. 7/1/2006) (replaces carrier #00811)
16013 = CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT — Noridian Healthcare Solutions, LLC (DME MAC)
16360 = Ohio — Nationwide Insurance Co. (eff. 1983; term. 2002)
16510 = West Virginia — Nationwide Insurance Co. (eff. 1983; term. 2002)
17003 = Administer Federal, Inc. (B) (eff. 7/1/2006) (replaces carrier #00635)
17013 = IL, IN, KY, MI, MN, OH, WI — CGS Administrators, LLC (DME MAC)
18003 = Connecticut General (CIGNA) (C) (eff. 06/2006) (replaces carrier #00885)
19003 = Noridian Mutual Ins. Co (D) (eff. 10/1/2006) (replaces carrier #05655)
31140 = North California — National Heritage Ins. (eff. 1997; term. 08/2008) (replaced by MAC #01102)
31142 = Maine — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced by MAC # 14102)
31143 = Massachusetts — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced by MAC # 14202)
31144 = New Hampshire — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced by MAC # 14302)
31145 = Vermont — National Heritage Ins. (eff. 1998; term. 05/2009)
31146 = South California — NHIC (eff. 2000; term. 08/2008)
66001 = Noridian Competitive Acquisition Program
80884 = Contractor ID for Physician Risk Adjustment Data (data not sent through NCH, but through Palmetto)

COMMENT: Values and websites referenced may change over time. Refer to this website for current information: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.

Prior to version H this field was named: FICARR_IDENT_NUM.

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CARR_PRFRNG_PIN_NUM

LABEL: Carrier Line Performing Provider ID Number (PIN)

DESCRIPTION: The provider identification number (PIN) of the physician/supplier (assigned by the Medicare Administrative Contractor [MAC]) who performed the service for this line item.

SHORT NAME: PRF_PRFL

LONG NAME: CARR_PRFRNG_PIN_NUM

TYPE: CHAR

LENGTH: 15

SOURCE: NCH

VALUES: —

COMMENT: CMS identifies providers using the National Provider Identifier (NPI; eff. May 1, 2007), which replaces legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

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CLAIM_QUERY_CODE

LABEL: Claim Query Code

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

SHORT NAME: QUERY_CD

LONG NAME: CLAIM_QUERY_CODE

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = Interim bill
3 = Final bill
5 = Debit adjustment

COMMENT: —

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CLM_ADJUST_GRP_CD

LABEL: Claim Adjustment Group Code

DESCRIPTION: Claim adjustment group code used to categorize a payment adjustment for a claim or claim line. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: CLM_ADJUST_GRP_CD

LONG NAME: CLM_ADJUST_GRP_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: CO = Contractual obligation
OA = Other adjustment
PR = Patient responsibility

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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CLM_ADJUST_RSN_CD

LABEL: Claim Adjustment Reason Code

DESCRIPTION: Claim Adjustment Reason Code used to describe why a claim or claim line was paid differently than billed. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: CLM_ADJUST_RSN_CD

LONG NAME: CLM_ADJUST_RSN_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: This is not a comprehensive list of values; refer to website below for current values and descriptions:
96 = Non-covered charge(s). At least one Remark Code must be provided
119 = Benefit maximum for this time period or occurrence has been reached
B9 = Patient is enrolled in a hospice

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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CLM_ADMSN_DT

LABEL: Claim Admission Date

DESCRIPTION: On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or religious non-medical health care institution, and starting October 2023, this field is added to reflect the admission date for hospice or to a home health agency (HHA).

SHORT NAME: ADMSN_DT (in the inpatient and SNF files)
HHSTRTDT (in the HHA file)
CLM_ADMSN_DT (in the hospice files)

LONG NAME: CLM_ADMSN_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: The admission date is a required field on inpatient and HHA claims. The Medicare rule is the admission date and the claim "from date" (field called CLM_FROM_DT) must be the same.

From 1/1/2020 until 10/2/2023, there was no direct way to determine the admission date for HHA. Prior to January 2020, when this variable appeared in the HHA it is the date the care began for the HHA services reported on the claim.

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

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CLM_BASE_OPRTG_DRG_AMT

LABEL: Claim Base Operating DRG Amount

DESCRIPTION: The amount of the wage adjusted DRG operating payment plus the technology add-on payment.

SHORT NAME: CLM_BASE_OPRTG_DRG_AMT

LONG NAME: CLM_BASE_OPRTG_DRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: This variable was new in 2011.

It is populated only for inpatient claims.

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CLM_BENE_ID_TYPE_CD

LABEL: Claim Beneficiary Identifier Type Code

DESCRIPTION: This field identifies whether the claim was submitted by the provider, during the transition period, with a HICN or MBI (for CMS internal use).

SHORT NAME: CLM_BENE_ID_TYPE_CD

LONG NAME: CLM_BENE_ID_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: M = MBI
H = HICN
Null/missing

COMMENT: This field is populated for CMS internal use. It was new in 2017.

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CLM_BENE_PD_AMT

LABEL: Carrier Claim Beneficiary Paid Amount

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

SHORT NAME: CLM_BENE_PD_AMT

LONG NAME: CLM_BENE_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CLM_BNDLD_ADJSTMT_PMT_AMT

LABEL: Claim Bundled Adjustment Payment Amount

DESCRIPTION: This field represents the amount the claim was reduced for those hospitals participating in Model 1 of the Bundled Payments for Care Improvement initiative (BPCI, Model 1).

SHORT NAME: CLM_BNDLD_ADJSTMT_PMT_AMT

LONG NAME: CLM_BNDLD_ADJSTMT_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: The hospital must be participating in the Model 1 of the Bundled Payments for Care Improvement initiative (refer to CLM_CARE_IMPRVMT_MODEL_CD1). The percentage of the discount that this amount represents is in the field called CLM_BNDLD_MODEL_1_DSCNT_PCT.

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

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CLM_BNDLD_MODEL_1_DSCNT_PCT

LABEL: Claim Bundled Model 1 Discount Percent

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

SHORT NAME: CLM_BNDLD_MODEL_1_DSCNT_PCT

LONG NAME: CLM_BNDLD_MODEL_1_DSCNT_PCT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: X.XX

COMMENT: The hospital must be participating in the Model 1 of the BPCI (refer to CLM_CARE_IMPRVMT_MODEL_CD1). The dollar amount of the payment reduction for the service is in the field called CLM_BNDLD_ADJSTMT_PMT_AMT.

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

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CLM_CARE_IMPRVMT_MODEL_CD1

CLM_CARE_IMPRVMT_MODEL_CD2

CLM_CARE_IMPRVMT_MODEL_CD3

CLM_CARE_IMPRVMT_MODEL_CD4

LABEL: Claim Care Improvement Model Code (bundled payment)

DESCRIPTION: This code is used to identify the care improvement model being used for bundling payments. The initiative if referred to as the Bundled Payments for Care Improvement initiative (BPCI).

SHORT NAME:

CLM_CARE_IMPRVMT_MODEL_CD1
CLM_CARE_IMPRVMT_MODEL_CD2
CLM_CARE_IMPRVMT_MODEL_CD3
CLM_CARE_IMPRVMT_MODEL_CD4

LONG NAME:

CLM_CARE_IMPRVMT_MODEL_CD1
CLM_CARE_IMPRVMT_MODEL_CD2
CLM_CARE_IMPRVMT_MODEL_CD3
CLM_CARE_IMPRVMT_MODEL_CD4

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
61 = Care Improvement Model 1 is used
62 = Care Improvement Model 2 is used
63 = Care Improvement Model 3 is used
64 = Care Improvement Model 4 is used
Null/missing

COMMENT: There are 4 of these Care Improvement Model fields (CLM_CARE_IMPRVMT_MODEL_CD1–CLM_CARE_IMPRVMT_MODEL_CD4).

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

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CLM_CLNCL_TRIL_NUM

LABEL: Clinical Trial Number

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

SHORT NAME: CCLTRNUM (in the carrier and DME files)
CLM_CLNCL_TRIL_NUM (in the IP, SNF, HHA, hospice and HOP files)

LONG NAME: CLM_CLNCL_TRIL_NUM

TYPE: CHAR

LENGTH: 8

SOURCE: NCH

VALUES: —

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

This field was effective September 1, 2008, for carrier and DME claims. Starting October 2023, this field is also available on institutional claims, i.e., inpatient, SNF, home health, hospice, and institutional outpatient claims. For institutional claims, the clinical trial number is also populated in the claim value amount field, when claim value code is equal to “D4.” CMS will continue to populate the clinical trial number in the claim value amount field, as well as this new field.

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CLM_DISP_CD

LABEL: Claim Disposition Code

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

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

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

SHORT NAME: DISP_CD

LONG NAME: CLM_DISP_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: 01 = Debit accepted

COMMENT: —

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CLM_DRG_CD

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

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

SHORT NAME: DRG_CD

LONG NAME: CLM_DRG_CD

TYPE: CHAR

LENGTH: 4

SOURCE: NCH

VALUES: —

COMMENT: Starting in January 2021 with NCH version L, this field changed from three characters to four.

GROUPER is the software that determines the DRG from data elements reported by the hospital.

Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment.

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

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CLM_DRG_OUTLIER_STAY_CD

LABEL: Claim Diagnosis Related Group Outlier Stay Code

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

SHORT NAME: OUTLR_CD

LONG NAME: CLM_DRG_OUTLIER_STAY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = No outlier
1 = Day outlier (condition code 60)
2 = Cost outlier (condition code 61)

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

COMMENT: —

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CLM_E_POA_IND_SW1

CLM_E_POA_IND_SW2

CLM_E_POA_IND_SW3

CLM_E_POA_IND_SW4

CLM_E_POA_IND_SW5

CLM_E_POA_IND_SW6

CLM_E_POA_IND_SW7

CLM_E_POA_IND_SW8

CLM_E_POA_IND_SW9

CLM_E_POA_IND_SW10

CLM_E_POA_IND_SW11

CLM_E_POA_IND_SW12

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

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

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

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

SHORT NAME:

CLM_E_POA_IND_SW1
CLM_E_POA_IND_SW2
CLM_E_POA_IND_SW3
CLM_E_POA_IND_SW4
CLM_E_POA_IND_SW5
CLM_E_POA_IND_SW6
CLM_E_POA_IND_SW7
CLM_E_POA_IND_SW8
CLM_E_POA_IND_SW9
CLM_E_POA_IND_SW10
CLM_E_POA_IND_SW11
CLM_E_POA_IND_SW12

LONG NAME:

CLM_E_POA_IND_SW1
CLM_E_POA_IND_SW2
CLM_E_POA_IND_SW3
CLM_E_POA_IND_SW4
CLM_E_POA_IND_SW5
CLM_E_POA_IND_SW6
CLM_E_POA_IND_SW7
CLM_E_POA_IND_SW8
CLM_E_POA_IND_SW9
CLM_E_POA_IND_SW10
CLM_E_POA_IND_SW11
CLM_E_POA_IND_SW12

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

Y = Diagnosis was present at the time of admission (POA)

N = Diagnosis was not present at the time of admission

U = Documentation is insufficient to determine if condition was present on admission

W = Provider is unable to clinically determine whether condition was present on admission

X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.

Z = Denotes the end of the POA indicators

1 = Unreported/not used — exempt from POA reporting — this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data

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

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CLM_FAC_TYPE_CD

LABEL: Claim Facility Type Code

DESCRIPTION: The type of facility.

SHORT NAME: FAC_TYPE

LONG NAME: CLM_FAC_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

The type of bill is the concatenation of two variables:

Facility type (CLM_FAC_TYPE_CD)

Service classification type (CLM_SRVC_CLSFCTN_TYPE_CD).

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CLM_FREQ_CD

LABEL: Claim Frequency Code

DESCRIPTION: The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care

SHORT NAME: FREQ_CD

LONG NAME: CLM_FREQ_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

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

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

Many different types of services can be billed on a Part A or Part B institutional claim and knowing the type of bill helps to distinguish them. The type of bill is the concatenation of three variables: the facility type (CLM_FAC_TYPE_CD), the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD), and the claim frequency code (CLM_FREQ_CD).

^ Back to TOC ^

CLM_FROM_DT

LABEL: Claim From Date

DESCRIPTION: The first day on the billing statement covering services rendered to the beneficiary (aka “Statement Covers From Date”).

SHORT NAME: FROM_DT

LONG NAME: CLM_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: For home health prospective payment system (PPS) claims, the “from” date and the “thru” date on the RAP (request for anticipated payment) initial claim must always match.

The "from" date on the claim may not always represent the first date of services, particularly for home health or hospice care. To obtain the date corresponding with the onset of services (or admission date) use the admission date from the claim (variable called CLM_ADMSN_DT for IP, SNF, and HH — and variable called CLM_HOSPC_START_DT_ID for hospice claims).

For Part B non-institutional (carrier and DME) services, this variable corresponds with the earliest of any of the line-item level dates (e.g., 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_FULL_STD_PYMT_AMT

LABEL: Claim Full Standard Payment Amount

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

This amount does not include any applicable outlier payment amount.

SHORT NAME: CLM_FULL_STD_PYMT_AMT

LONG NAME: CLM_FULL_STD_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

For a LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the four fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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CLM_HHA_LUPA_IND_CD

LABEL: Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code

DESCRIPTION: The code used to identify those home health PPS claims that have 4 visits or less in a 60-day episode.

If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of home health resource groups (HHRGs).

SHORT NAME: LUPAIND

LONG NAME: CLM_HHA_LUPA_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: L = Low utilization payment adjustment (LUPA) claim
Blank = Not a LUPA claim; process using home health resource groups (HHRG)

COMMENT: Beginning 10/1/2000, this field was populated with data. Claims processed prior to 10/1/2000 contained spaces.

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CLM_HHA_RFRL_CD

LABEL: Claim HHA Referral Code

DESCRIPTION: Effective with version "I", the code used to identify the means by which the beneficiary was referred for home health services.

SHORT NAME: HHA_RFRL

LONG NAME: CLM_HHA_RFRL_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

1 = Physician referral — the patient was admitted upon the recommendation of a personal physician

2 = Clinic referral — the patient was admitted upon the recommendation of this facility's clinic physician

3 = HMO referral — the patient was admitted upon the recommendation of a health maintenance organization (HMO) physician

4 = Transfer from hospital — the patient was admitted as an inpatient transfer from an acute care facility

5 = Transfer from a skilled nursing facility (SNF) — the patient was admitted as an inpatient transfer from a SNF

6 = Transfer from another health care facility — the patient was admitted as a transfer from a health care facility other than an acute care facility or SNF

7 = Emergency room — the patient was admitted upon the recommendation of this facility's emergency room physician

8 = Court/law enforcement — the patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative

9 = Information not available — the means the patient was admitted is not known

A = Transfer from a critical access hospital — patient was admitted/referred to this facility as a transfer from a critical access hospital

B = Transfer from another HHA — beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS (eff.10/2000)

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

D = Unknown/invalid code

COMMENT: The use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/2000)

Beginning October 1, 2000, this field was populated with data. Claims processed prior to October 1, 2000, contained spaces in this field.

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CLM_HHA_TOT_VISIT_CNT

LABEL: Claim HHA Total Visit Count

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

SHORT NAME: VISITCNT

LONG NAME: CLM_HHA_TOT_VISIT_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: —

COMMENT: Derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X, and 059X). Value 999 will be displayed if the sum of the revenue center unit count equals or exceeds 999.

Effective July 1, 1999, all HHA claims received with service from dates July 1, 1999, and after will be processed as if the units field contains the 15-minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.

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CLM_HOSPC_START_DT_ID

LABEL: Claim Hospice Start Date

DESCRIPTION: The start date of the beneficiary's hospice period of coverage. Applies only to institutional hospice claims.

SHORT NAME: HSPCSTRT

LONG NAME: CLM_HOSPC_START_DT_ID

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is no longer populated. Starting in 2020, use the CLM_ADMSN_DT.

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CLM_HRR_ADJSTMT_PCT

LABEL: Claim HRR Adjustment Percent

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

SHORT NAME: CLM_HRR_ADJSTMT_PCT

LONG NAME: CLM_HRR_ADJSTMT_PCT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: X.XXXX

COMMENT: The ACA (Section 3025) requires CMS to reduce payments to subsection (d) inpatient prospective payment system (IPPS) hospitals with excess readmissions. There is a variable that indicates whether the hospital was excluded from the HRR program (reference CLM_HRR_PRTCPNT_IND_CD). This percentage reduction is applied to the base operating DRG amount (defined as the wage adjusted DRG payment plus new technology add-on payments).

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

The actual dollar amount of the adjustment that applied to the claim is found in the variable called CLM_HRR_ADJSTMT_PMT_AMT.

This initiative began in fourth quarter of 2012 (e.g., beginning of federal fiscal year 13).

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

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CLM_HRR_ADJSTMT_PMT_AMT

LABEL: Claim Hospital Readmission Reduction (HRR) Adjustment Payment Amount

DESCRIPTION: This field represents the Hospital Readmission Reduction (HRR) Program Payment Amount. The amount is the reduction to the claim for a readmission.

SHORT NAME: CLM_HRR_ADJSTMT_PMT_AMT

LONG NAME: CLM_HRR_ADJSTMT_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX (may be a negative value)

COMMENT: The ACA (Section 3025) requires CMS to reduce payments to subsection (d) inpatient prospective payment system (IPPS) hospitals with excess readmissions. There is a variable that indicates whether the hospital was excluded from the HRR program (reference CLM_HRR_PRTCPNT_IND_CD). This percentage reduction is applied to the base operating DRG amount (defined as the wage adjusted DRG payment plus new technology add-on payments).

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

This amount is based on a percent (CLM_HRR_ADJSTMT_PCT).

This initiative began in fourth quarter of 2012 (i.e., beginning of federal fiscal year 13).

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

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CLM_HRR_PRTCPNT_IND_CD

LABEL: Claim Hospital Readmission Reduction (HRR) Participant Indicator Code

DESCRIPTION: This field is the code used to identify whether the hospital is participating in the Hospital Readmissions Reduction (HRR) program.

SHORT NAME: CLM_HRR_PRTCPNT_IND_CD

LONG NAME: CLM_HRR_PRTCPNT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = Not participating
1 = Participating and not equal to 1.0000
2 = Participating and equal to 1.0000
Null/missing = Not participating

COMMENT: The ACA (Section 3025) requires CMS to reduce payments to inpatient prospective payment system (IPPS) hospitals with excess readmissions.

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

This initiative began in fourth quarter of 2012 (i.e., beginning of federal fiscal year 13).

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

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CLM_ID

LABEL: Claim ID

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

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

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

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

SHORT NAME: CLM_ID

LONG NAME: CLM_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

VALUES: —

COMMENT: The CLM_ID is assigned by the CCW. The CLM_ID is specific to the CCW and is not applicable to any other identification system or data source.

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

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CLM_IP_ADMSN_TYPE_CD

LABEL: Claim Inpatient Admission Type Code

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

SHORT NAME: TYPE_ADM

LONG NAME: CLM_IP_ADMSN_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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CLM_IP_INITL_MS_DRG_CD

LABEL: Claim Inpatient Initial MS DRG Code

DESCRIPTION: Claim inpatient Initial MS Diagnosis Related Group (DRG) Code

SHORT NAME: CLM_IP_INITL_MS_DRG_CD

LONG NAME: CLM_IP_INITL_MS_DRG_CD

TYPE: CHAR

LENGTH: 4

SOURCE: NCH

VALUES: XXXX

COMMENT: This field identifies the initial MS-DRG code assigned by MS-DRG Grouper prior to application of Hospital Acquired Conditions (HAC) logic. The data will only be populated on inpatient claims.

Data will not start coming in until July 2019.

^ Back to TOC ^

CLM_IP_LOW_VOL_PMT_AMT

LABEL: Claim Inpatient Low Volume Payment Amount

DESCRIPTION: This is the amount field used to identify a payment adjustment given to hospitals to account for the higher costs per discharge for low-income hospitals under the inpatient prospective payment system (IPPS).

SHORT NAME: CLM_IP_LOW_VOL_PMT_AMT

LONG NAME: CLM_IP_LOW_VOL_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Payment adjustment for low income IPPS hospitals.

This field was new in 2011.

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CLM_LINE_NUM

LABEL: Claim Line Number

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

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

All revenue center records or claim lines on a given claim have the same CLM_ID.

SHORT NAME: CLM_LN

LONG NAME: CLM_LINE_NUM

TYPE: NUM

LENGTH: 13

SOURCE: CCW

VALUES: —

COMMENT: —

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CLM_MCO_PD_SW

LABEL: Claim MCO Paid Switch

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

SHORT NAME: MCOPDSW

LONG NAME: CLM_MCO_PD_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

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CLM_MDCL_REC

LABEL: Claim Medical Record Number

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

SHORT NAME: CLM_MDCL_REC

LONG NAME: CLM_MDCL_REC

TYPE: CHAR

LENGTH: 17

SOURCE: NCH

VALUES: —

COMMENT: This variable may be null/missing.

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CLM_MDCR_NON_PMT_RSN_CD

LABEL: Claim Medicare Non-Payment Reason Code

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

SHORT NAME: NOPAY_CD

LONG NAME: CLM_MDCR_NON_PMT_RSN_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

A = Covered worker's compensation (Obsolete)

B = Benefit exhausted

C = Custodial care — non-covered care (includes all "beneficiary at fault" waiver cases) (Obsolete)

E = HMO out-of-plan services not emergency or urgently needed (Obsolete)

E = MSP cost avoided — IRS/SSA/HCFA Data Match (eff. 7/2000)

F = MSP cost avoids HMO Rate Cell (eff. 7/2000)

G = MSP cost avoided Litigation Settlement (eff. 7/2000)

H = MSP cost avoided Employer Voluntary Reporting (eff. 7/2000)

J = MSP cost avoids Insurer Voluntary Reporting (eff. 7/2000)

K = MSP cost avoids Initial Enrollment Questionnaire (eff. 7/2000)

N = All other reasons for non-payment

P = Payment requested

Q = MSP cost avoided Voluntary Agreement (eff. 7/2000)

R = Benefits refused, or evidence not submitted

T = MSP cost avoided — IEQ contractor (eff. 9/1976) (obsolete 6/30/2000)

U = MSP cost avoided — HMO rate cell adjustment (eff. 9/1976) (Obsolete 6/30/2000)

V = MSP cost avoided — litigation settlement (eff. 9/1976) (Obsolete 6/30/2000)

W = Worker's compensation (Obsolete)

X = MSP cost avoided — generic

Y = MSP cost avoided — IRS/SSA data match project (obsolete 6/30/2000)

Z = Zero reimbursement RAPs — zero reimbursement made due to medical review intervention or where provider specific zero payment has been determined. (eff. with HHPPS — 10/2000)

00 = MSP cost avoided — COB Contractor

12 = MSP cost avoided — BCBS Voluntary Agreements

13 = MSP cost avoided — Office of Personnel Management

14 = MSP cost avoided — Workman's Compensation (WC) Datamatch

15 = MSP cost avoided — Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)

16 = MSP cost avoided — Liability Insurer VDSA (eff. 4/2006)

17 = MSP cost avoided — No-Fault Insurer VDSA (eff. 4/2006)

18 = MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006)

19 = REFERENCE NOTE4: Coordination of Benefits Contractor 11119 (reference CMS Change Request 7906 for identification of the contractor.)

21 = MSP cost avoided — MIR Group Health Plan (eff. 1/2009)

22 = MSP cost avoided — MIR non-Group Health Plan (eff. 1/2009)

25 = MSP cost avoided — Recovery Audit Contractor — California (eff. 10/2005)

26 = MSP cost avoided — Recovery Audit Contractor — Florida (eff. 10/2005)

42 = REFERENCE NOTE4: Coordination of Benefits Contractor 11142 (reference CMS Change Request 7906 for identification of the contractor.)

43 = REFERENCE NOTE4: Coordination of Benefits Contractor 11143 (reference CMS Change Request 7906 for identification of the contractor.)

Effective 4/1/2002, the Medicare nonpayment reason code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH and NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

! = MSP cost avoided — COB Contractor (“00” 2-byte code)

@ = MSP cost avoided — BC/BS Voluntary Agreements (“12” 2-byte code)

= MSP cost avoided — Office of Personnel Management (“13” 2-byte code)

$ = MSP cost avoided — Workman's Compensation (WC) Datamatch (“14” 2-byte code)

* =MSP cost avoided — Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (“15” 2-byte code) (eff. 4/2006)

(= MSP cost avoided — Liability Insurer VDSA (“16” 2-byte code) (eff. 4/2006)

) = MSP cost avoided — No-Fault Insurer VDSA (“17” 2-byte code) (eff. 4/2006)

+ = MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (“18” 2-byte code) (eff. 4/2006)

< = MSP cost avoided — MIR Group Health Plan (“21” 2-byte code) (eff. 1/2009)

> = MSP cost avoided — MIR non-Group Health Plan (“22” 2-byte code) (eff. 1/2009)

% = MSP cost avoided — Recovery Audit Contractor — California (“25” 2-byte code) (eff. 10/2005)

& = MSP cost avoided — Recovery Audit Contractor — Florida (“26” 2-byte code) (eff. 10/2005)

COMMENT: This field was put on all institutional claim types, but data did not start coming in on OP/HHA/hospice until April 1, 2002. Prior to April 1, 2002, data only came in inpatient/SNF claims.

Effective April 1, 2002, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current one-byte field but instituted a crosswalk of the two-byte field to the one-byte character value. Reference table of code for the crosswalk.

NOTE: Effective with version “J,” the field has been expanded on the NCH claim to two bytes. With this expansion the NCH will no longer use the character values to represent the official two-byte values being sent in by NCH since April 1, 2002.

During the version “J” conversion, all character values were converted to the two-byte values.

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CLM_MODEL_4_READMSN_IND_CD

LABEL: Claim Model 4 Readmission Indicator Code

DESCRIPTION: This field identifies the method of payment of a claim billed within 30 days of a Model 4 Bundled Payments for Care Improvement (BPCI) admission.

SHORT NAME: CLM_MODEL_4_READMSN_IND_CD

LONG NAME: CLM_MODEL_4_READMSN_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = claim is related readmission to a Model 4 BPCI claim and shall pay IME, DSH, and capital only

2 = two Model 4 BPCI claims within 30 days of each other, first claim in episode shall process as it would in the absence of Model 4 BPCI

3 = two Model 4 BPCI claims within 30 days of each other, this is the second claim in the episode and paid as Model 4

Null/missing = not a BPCI claim

COMMENT: Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients. Under the Model 4 BPCI pilot, CMS will reimburse qualified acute care hospitals a blended payment for hospital inpatient care and physician services connected with a single episode of care. This will occur in association with inpatient hospital claims that the BPCI participating hospital will bill to their jurisdictional A/B MAC as type of bill 11X claims.

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CLM_MODEL_REIMBRSMT_AMT

LABEL: Claim Model Reimbursement Amount

DESCRIPTION: This field is used to identify the "net reimbursement amount" of what Medicare would have paid for global budget services from a hospital participating in the particular model. If the claim only includes global services, the reimbursement amount (CLM_PMT_AMT) will reflect $0. If the claim includes global and non-global services, the reimbursement amount will reflect the amount Medicare actually paid for the non-global services.

SHORT NAME: CLM_MODEL_REIMBRSMT_AMT

LONG NAME: CLM_MODEL_REIMBRSMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

COMMENT: This field is new in January 2020. This field only applies to Part A claims.

This model reimbursement amount applies to the Pennsylvania Rural Health Model (PARHM) (CR11355). A demo code (variable called DEMO_ID_NUM) will be assigned for future models. CLM_RLT_COND_CD = M6 (on the occurrence code file) and CLM_VAL_CD = Q4 (on the value code file) have been created to identify the PARH model.

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CLM_NEXT_GNRTN_ACO_IND_CD1

CLM_NEXT_GNRTN_ACO_IND_CD2

CLM_NEXT_GNRTN_ACO_IND_CD3

CLM_NEXT_GNRTN_ACO_IND_CD4

CLM_NEXT_GNRTN_ACO_IND_CD5

LABEL: Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code

DESCRIPTION: The field identifies the claims that qualify for specific claims processing edits related to benefit enhancement through the Next Generation (NG) Accountable Care Organization (ACO). This field populates the ACO indicators for all models, not just NG ACO.

SHORT NAME:

CLM_NEXT_GNRTN_ACO_IND_CD1
CLM_NEXT_GNRTN_ACO_IND_CD2
CLM_NEXT_GNRTN_ACO_IND_CD3
CLM_NEXT_GNRTN_ACO_IND_CD4
CLM_NEXT_GNRTN_ACO_IND_CD5

LONG NAME:

CLM_NEXT_GNRTN_ACO_IND_CD1
CLM_NEXT_GNRTN_ACO_IND_CD2
CLM_NEXT_GNRTN_ACO_IND_CD3
CLM_NEXT_GNRTN_ACO_IND_CD4
CLM_NEXT_GNRTN_ACO_IND_CD5

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
0 = Base record (no enhancements)
1 = Population based payments (PBP)
2 = Telehealth
3 = Post discharge home health Visits
4 = 3-Day SNF waiver
5 = Capitation
6 = CEC telehealth
7 = Care management home visits
8 = Primary Care Capitation (PCC)
9 = Home health benefit enhancement — eff. 4/2021
A = Diabetic shoes – eff. 10/2023
B = Concurrent care for beneficiaries that elect the Medicare hospice benefit — eff. 4/2021
C = Kidney disease education (KDE) — eff. 4/2021
D = Seriously Ill population (SIP)
E = Flat visit fee (FVF)
F = Quarterly Capitation Payment (QCP) — eff. 4/2021
G = Performance based adjustment (PBA) — eff. 7/2022
H = Home infusion therapy – eff. 10/2023

I = Medical nutrition therapy – eff. 10/2023
J = Hospice care – eff. 10/2023
K = Cardiac and pulmonary rehabilitation – eff. 10/2023
L = Making Care Primary (MCP) Benefit Enhancement Indicator Track 1
M = Making Care Primary (MCP) Benefit Enhancement Indicator Track 2
N = Making Care Primary (MCP) Benefit Enhancement Indicator Track 3
O = GUIDE Model Beneficiary covering all services
Z0 = PACE straddle claim

COMMENT: These fields were added to the DME claim lines October 2023. The Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model made changes to expand services to allow for nurse practitioners and physician assistants to certify, order and refer certain Medicare services. Previously, these fields were on the carrier claims (on the line file) and on all institutional claim types (inpatient, SNF, HHA, hospice, and outpatient) at the claim-level.

There are five occurrences of this field on a claim (or claim line), but each value can only be represented once. The five occurrences of this field are found at the claim level on all institutional claim types and at the line level on Part B carrier and DME claims.

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CLM_NON_UTLZTN_DAYS_CNT

LABEL: Claim Medicare Non-Utilization Days Count

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

SHORT NAME: NUTILDAY

LONG NAME: CLM_NON_UTLZTN_DAYS_CNT

TYPE: NUM

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_OP_BENE_PMT_AMT

LABEL: Claim Outpatient Payment Amount to Beneficiary

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

SHORT NAME: BENEPMT

LONG NAME: CLM_OP_BENE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

^ Back to TOC ^

CLM_OP_ESRD_MTHD_CD

LABEL: Claim Outpatient End-stage Renal Disease (ESRD) Method of Reimbursement Code

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

SHORT NAME: CLM_OP_ESRD_MTHD_CD

LONG NAME: CLM_OP_ESRD_MTHD_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

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CLM_OP_PPS_IND

LABEL: Claim Outpatient prospective payment system (OPPS) Indicator

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

SHORT NAME: CLM_OP_PPS_IND

LONG NAME: CLM_OP_PPS_IND

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = OPPS
2 = Non-OPPS

COMMENT: A blank, zero or any other value is defaulted to 1. This field is not populated prior to 2021.

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CLM_OP_PRVDR_PMT_AMT

LABEL: Claim Outpatient Provider Payment Amount

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

SHORT NAME: PRVDRPMT

LONG NAME: CLM_OP_PRVDR_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CLM_OP_TRANS_TYPE_CD

LABEL: Claim Outpatient transaction type

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

SHORT NAME: CLM_OP_TRANS_TYPE_CD

LONG NAME: CLM_OP_TRANS_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

A = Outpatient Psychiatric hospital
B = Outpatient tuberculosis (TB) hospital
C = Outpatient General Care hospital
D = Outpatient skilled nursing facility (SNF)
E = Home health agency
F = Comprehensive Health Care
G = Clinical Rehab agency
H = Rural Health Clinic
I = Satellite Dialysis Facility
J = Limited Care Facility
0 = Christian Science SNF
1 = Psychiatric hospital Facility
2 = TB hospital Facility
3 = General Care hospital
4 = Regular SNF
Spaces = Home health/hospice

COMMENT: —

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CLM_PASS_THRU_PER_DIEM_AMT

LABEL: Claim Pass Thru Per Diem Amount

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

To determine the total of the pass-through payments for a hospitalization, this field should be multiplied by the claim Medicare utilization day count (CLM_UTLZTN_DAY_CNT). Then, total Medicare payments for a hospitalization claim can be determined by summing this product and the CLM_PMT_AMT field.

SHORT NAME: PER_DIEM

LONG NAME: CLM_PASS_THRU_PER_DIEM_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" Reference: and also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" Reference the list of MLN publications at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospice

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CLM_PMT_AMT

LABEL: Claim (Medicare) Payment Amount

DESCRIPTION: The Medicare claim payment amount.

For hospital services, this amount does not include the claim pass-through per diem payments made by Medicare. To obtain the total amount paid by Medicare for the claim, the pass-through amount (which is the daily per diem amount) must be multiplied by the number of Medicare-covered days (e.g., multiply the CLM_PASS_THRU_PER_DIEM_AMT by the CLM_UTLZTN_DAY_CNT), and then added to the claim payment amount (this field).

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

For Part B non-institutional services (carrier and DME), this variable equals the sum of all the line item-level Medicare payments (variable called the LINE_NCH_PMT_AMT).

SHORT NAME: PMT_AMT

LONG NAME: CLM_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_POA_IND_SW1
CLM_POA_IND_SW2
CLM_POA_IND_SW3
CLM_POA_IND_SW4
CLM_POA_IND_SW5
CLM_POA_IND_SW6
CLM_POA_IND_SW7
CLM_POA_IND_SW8
CLM_POA_IND_SW9
CLM_POA_IND_SW10
CLM_POA_IND_SW11
CLM_POA_IND_SW12
CLM_POA_IND_SW13
CLM_POA_IND_SW14
CLM_POA_IND_SW15
CLM_POA_IND_SW16
CLM_POA_IND_SW17
CLM_POA_IND_SW18
CLM_POA_IND_SW19
CLM_POA_IND_SW20
CLM_POA_IND_SW21
CLM_POA_IND_SW22
CLM_POA_IND_SW23
CLM_POA_IND_SW24
CLM_POA_IND_SW25

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

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

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

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

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

SHORT NAME:

CLM_POA_IND_SW1
CLM_POA_IND_SW2
CLM_POA_IND_SW3
CLM_POA_IND_SW4
CLM_POA_IND_SW5
CLM_POA_IND_SW6
CLM_POA_IND_SW7
CLM_POA_IND_SW8
CLM_POA_IND_SW9
CLM_POA_IND_SW10
CLM_POA_IND_SW11
CLM_POA_IND_SW12
CLM_POA_IND_SW13
CLM_POA_IND_SW14
CLM_POA_IND_SW15
CLM_POA_IND_SW16
CLM_POA_IND_SW17
CLM_POA_IND_SW18
CLM_POA_IND_SW19
CLM_POA_IND_SW20

CLM_POA_IND_SW21
CLM_POA_IND_SW22
CLM_POA_IND_SW23
CLM_POA_IND_SW24
CLM_POA_IND_SW25

LONG NAME:

CLM_POA_IND_SW1
CLM_POA_IND_SW2
CLM_POA_IND_SW3
CLM_POA_IND_SW4
CLM_POA_IND_SW5
CLM_POA_IND_SW6
CLM_POA_IND_SW7
CLM_POA_IND_SW8
CLM_POA_IND_SW9
CLM_POA_IND_SW10
CLM_POA_IND_SW11
CLM_POA_IND_SW12
CLM_POA_IND_SW13
CLM_POA_IND_SW14
CLM_POA_IND_SW15
CLM_POA_IND_SW16
CLM_POA_IND_SW17
CLM_POA_IND_SW18
CLM_POA_IND_SW19
CLM_POA_IND_SW20
CLM_POA_IND_SW21
CLM_POA_IND_SW22
CLM_POA_IND_SW23
CLM_POA_IND_SW24
CLM_POA_IND_SW25

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: Prior to version "J," the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

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

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CLM_PPS_CPTL_DRG_WT_NUM

LABEL: Claim PPS Capital DRG Weight Number

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

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

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

SHORT NAME: DRGWTAMT

LONG NAME: CLM_PPS_CPTL_DRG_WT_NUM

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/)

Also, in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT

LABEL: Claim PPS Capital Disproportionate Share Amount

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

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

SHORT NAME: DISP_SHR

LONG NAME: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also, in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference:).

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CLM_PPS_CPTL_EXCPTN_AMT

LABEL: Claim PPS Capital Exception Amount

DESCRIPTION: The capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

SHORT NAME: CPTL_EXP

LONG NAME: CLM_PPS_CPTL_EXCPTN_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/)

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_PPS_CPTL_FSP_AMT

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

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

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

SHORT NAME: CPTL_FSP

LONG NAME: CLM_PPS_CPTL_FSP_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/)

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference:https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_PPS_CPTL_IME_AMT

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

DESCRIPTION: The amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress to augment normal prospective payment system [PPS] payments for teaching hospitals to compensate them for higher patient costs resulting from medical education programs for interns and residents) portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

SHORT NAME: IME_AMT

LONG NAME: CLM_PPS_CPTL_IME_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_PPS_CPTL_OUTLIER_AMT

LABEL: Claim PPS Capital Outlier Amount

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

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

SHORT NAME: CPTLOUTL

LONG NAME: CLM_PPS_CPTL_OUTLIER_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/)

Also, in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_PPS_IND_CD

LABEL: Claim PPS Indicator Code

DESCRIPTION: The code indicating whether or not:

(1) the claim is from the prospective payment system (PPS), and/or

(2) the beneficiary is a deemed insured MQGE (Medicare Qualified Government Employee)

SHORT NAME: PPS_IND

LONG NAME: CLM_PPS_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Blank = Not a PPS bill or PPS does not exist
2 = PPS bill

COMMENT: —

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CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT

LABEL: Claim PPS Old Capital Hold Harmless Amount

DESCRIPTION: This amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to "A".

The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.

SHORT NAME: HLDHRMLS

LONG NAME: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" (reference: https://www.medpac.gov/document-type/payment-basic/).

Also, in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_PRCR_RTRN_CD

LABEL: Claim Pricer Return Code

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

SHORT NAME: CLM_PRCR_RTRN_CD

LONG NAME: CLM_PRCR_RTRN_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

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

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

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

Inpatient Hospital Payment return codes:

00 = Paid normal DRG payment

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

02 = Paid as a cost outlier

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

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

06 = Provider refused cost outlier

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

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

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

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

33 = For inpatient PPS, it means paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric

Inpatient Hospital Error return codes:

51 = No provider specific information found

52 = Invalid MSA# in provider file

53 = Waiver state — not calculated by PPS

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

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

56 = Invalid length of stay

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

58 = Total charges not numeric

61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60

62 = Invalid number of covered days

65 = PAY-CODE not = A, B or C on provider specific file for capital

67 = Cost outlier with LOS > covered days

Inpatient Rehab Facility (IRF) Pricer Return Codes

IRF Payment return codes:

00 = Paid normal CMG payment without outlier

01 = Paid normal CMG payment with outlier

02 = Transfer paid on a per diem basis without outlier

03 = Transfer paid on a per diem basis with outlier

04 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — without outlier

05 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — with outlier

06 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — without outlier

07 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — with outlier

10 = Paid normal CMG payment with penalty without outlier

11 = Paid normal CMG payment with penalty with outlier

12 = Transfer paid on a per diem basis with penalty without outlier

13 = Transfer paid on a per diem basis with penalty with outlier

14 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — with penalty without outlier

15 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — with penalty with outlier

16 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — with penalty without outlier

17 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — with penalty with outlier

IRF Error return codes:

50 = Provider specific rate not numeric

51 = Provider record terminated

52 = Invalid wage index

53 = Waiver state — not calculated by PPS

54 = CMG on claim not found in table

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

56 = Invalid length of stay

57 = Provider specific rate zero when blended payment requested

58 = Total covered charges not numeric

59 = Provider specific record not found

60 = MSA wage index record not found

61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60

62 = Invalid number of covered days

65 = Operating cost-to-charge ratio not numeric

67 = Cost outlier with LOS > covered days or cost outlier threshold calculation

72 = Invalid blend indicator (not 3 or 4)

73 = Discharged before provider FY begin date

74 = Provider FY begin date not in 2002

Long-Term Care Hospital (LTCH) Pricer Return Codes

LTCH Payment return codes:

00 = Normal DRG payment without outlier

01 = Normal DRG payment with outlier

02 = Short stay payment without outlier

03 = Short stay payment with outlier

04 = Blend year 1 — 80% facility rate plus 20% normal DRG payment without outlier

05 = Blend year 1 — 80% facility rate plus 20% normal DRG payment with outlier

06 = Blend year 1 — 80% facility rate plus 20% short stay payment without outlier

07 = Blend year 1 — 80% facility rate plus 20% short stay payment with outlier

08 = Blend year 2 — 60% facility rate plus 40% normal DRG payment without outlier

09 = Blend year 2 — 60% facility rate plus 40% normal DRG payment with outlier

10 = Blend year 2 — 60% facility rate plus 40% short stay payment without outlier

11 = Blend year 2 — 60% facility rate plus 40% short stay payment with outlier

12 = Blend year 3 — 40% facility rate plus 60% normal DRG payment without outlier

13 = Blend year 3 — 40% facility rate plus 60% normal DRG payment with outlier

14 = Blend year 3 — 40% facility rate plus 60% short stay payment without outlier

15 = Blend year 3 — 40% facility rate plus 60% short stay payment with outlier

16 = Blend year 4 — 20% facility rate plus 80% normal DRG payment without outlier

17 = Blend year 4 — 20% facility rate plus 80% normal DRG payment with outlier

18 = Blend year 4 — 20% facility rate plus 80% short stay payment without outlier

19 = Blend year 4 — 20% facility rate plus 80% short stay payment with outlier

20 = Short stay payment based on estimated cost without outlier

21 = Short stay payment based on LTC-DRG per diem without outlier

22 = For long-term care PPS, it means short stay payment based on blend of LTC-DRG PER DIEM and IPPS comparable amount without outlier

23 = Short stay payment based on estimated cost with outlier

24 = Short stay payment based on LTC-DRG per diem with outlier

25 = Short stay payment based on blend of LTC-DRG per diem and IPPS comp amt with outlier

26 = For long-term care PPS, it means short stay payment based on IPPS-comparable threshold without outlier

27 = Short stay payment based on IPPS comparable threshold with outlier

28 = Subclause (II) without outlier

29 = Subclause (II) with outlier

LTCH Error return codes:

50 = Provider specific rate not numeric

51 = Provider record terminated

52 = Invalid wage index

53 = Waiver state — not calculated by PPS

54 = DRG on claim not found in table

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

56 = Invalid length of stay

57 = Provider specific rate zero when blended payment requested

58 = Total covered charges not numeric

59 = Provider specific record not found

60 = MSA wage index record not found

61 = Lifetime reserve days not numeric or lifetime reserve days greater than 60

62 = Invalid number of covered days or covered days < lifetime reserve days

65 = Operating cost-to-charge ratio not numeric

67 = Cost outlier with length of stay > covered days

68 = Provider specific state code invalid

72 = Invalid blend indicator (not 1 thru 5)

73 = Discharged before provider FY begin date

74 = Provider FY begin date not in 2002

A0 = Blend yr, site-neutral based on cost, psych/rehab

A1 = Blend yr, site-neutral based on cost, outlier, psych/rehab

A2 = Blend yr, site-neutral based on cost, SSO, psych/rehab

A3 = Blend yr, site-neutral based on cost, SSO, outlier, psych/rehab

A4 = Blend yr, site-neutral based on IPPS, psych/rehab

A5 = Blend yr, site-neutral based on IPPS, outlier, psych/rehab

A6 = Blend yr, site-neutral based on IPPS, SSO, psych/rehab

A7 = Blend yr, site-neutral based on IPPS, SSO, outlier, psych/rehab

AA = Site-neutral based on cost, psych/rehab

AB = Site-neutral based on IPPS, psych/rehab

AC = Site-neutral based on IPPS, outlier, psych/rehab

B0 = Blend yr, site-neutral based on cost, vent

B1 = Blend yr, site-neutral based on cost, outlier, vent

B2 = Blend yr, site-neutral based on cost, SSO, vent

B3 = Blend yr, site-neutral based on cost, SSO, outlier, vent

B4 = Blend yr, site-neutral based on IPPS, vent

B5 = Blend yr, site-neutral based on IPPS, outlier, vent

B6 = Blend yr, site-neutral based on IPPS, SSO, vent

B7 =Blend yr, site-neutral based on IPPS, SSO, outlier, vent

BA = Site-neutral based on cost, vent

BB = Site-neutral based on IPPS, vent

BC = Site-neutral based on IPPS, outlier, vent

BD = SSO standard payment, vent

BE = SSO standard payment, outlier, vent

BF = Standard payment full DRG, vent

BG = Standard payment full DRG, outlier, vent

C0 = Blend yr, site-neutral based on cost, no vent

C1 = Blend yr, site-neutral based on cost, outlier, no vent

C2 = Blend yr, site-neutral based on cost, SSO, no vent

C3 = Blend yr, site-neutral based on cost, SSO, outlier, no vent

C4 = Blend yr, site-neutral based on IPPS, no vent

C5 = Blend yr, site-neutral based on IPPS, outlier, no vent

C6 = Blend yr, site-neutral based on IPPS, SSO, no vent

C7 = Blend yr, site-neutral based on IPPS, SSO, outlier, no vent

CA = Site-neutral based on cost, no vent

CB = Site-neutral based on IPPS, no vent

CC = Site-neutral based on IPPS, outlier, no vent

CD = SSO standard payment, no vent

CE = SSO standard payment, outlier, no vent

CF = Standard payment full DRG, no vent

CG = Standard payment full DRG, outlier, no vent

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

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

SNF payment return codes:

00 = RUG III group rate returned

SNF Error return codes:

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

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

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

Hospice payment return codes:

00 = Home rate returned

Hospice Error return codes:

10 = Bad units
20 = Bad units 2 < 8
30 = Bad MSA code
40 = Bad hospice wage index from MSA file
50 = Bad bene wage index from MSA file
51 = Bad provider number

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

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

Home health payment return codes:

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

Home health error return codes:

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

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

Outpatient PPS payment return codes:

01 = Line processed to payment

20 = Line processed but payment = 0 bene deductible = > adjusted payment

22 = For outpatient PPS, it means daily coinsurance limitation

Outpatient PPS error return codes:

30 = Missing, deleted, or invalid APC

38 = Missing or invalid discount factor

40 = Invalid service indicator passed by the OCE

41 = Service indicator invalid for OPPS PRICER

42 = APC = “00000” or (packaging flag = 1 or 2)

43 = Payment indicator not = to 1 or 5 thru 9

44 = Service indicator = “H” but payment indicator not = to 6

45 = Packaging flag not = to 0

46 = Line-item denial/reject flag not = to 0 or line-item denial/reject flag = to 1 and (APC not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325 or 0373 or 0374)) or line-item action flag not = to 1

47 = Line-item action flag = 2 or 3

48 = Payment adjustment flag not valid

49 = Site of service flag not = to 0 or (APC 0033 is not on the claim and service indicator = “P” or APC = 0322, 0325, 0373, 0374)

50 = Wage index not located

51 = Wage index equals zero

52 = Provider specific file wage index reclassification code invalid or missing

53 = Service from date not numeric or < 20000801

54 = Service from date < provider effective date or service from date > provider termination date

End-stage Renal Disease (ESRD) Pricer Return Codes

ESRD payment return codes:

00 = ESRD PPS payment calculated

01 = ESRD facility rate > zero

ESRD error return codes:

22 = For ESRD Pricer, it means PPS w/acute comorbid, training
26 = For ESRD Pricer, it means PPS w/chronic comorbid, low volume, training
31 = ESRD Pricer means PPS w/low BMI
32 = ESRD Pricer means PPS w/low volume, onset
33 = For ESRD Pricer, it means PPS w/outlier, training
50 = ESRD facility rate not numeric
52 = Provider type not = “40” or “41”
53 = Special payment indicator not = “1” or blank
54 = Date of birth not numeric or = zero
55 = Patient weight not numeric or = zero
56 = Patient height not numeric or = zero
57 = Revenue center code not in range
58 = Condition code not = “73” or “74” or blank
60 = MSA wage adjusted rate record not found
98 = Claim through date before 4/1/2005 or not numeric

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

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CLM_PRCR_VRSN_CD

LABEL: Claim Pricer version Code

DESCRIPTION: This field indicates the prospective payment system (PPS) Pricer version used to process payment for the claim.

SHORT NAME: CLM_PRCR_VRSN_CD

LONG NAME: CLM_PRCR_VRSN_CD

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: These are examples of observed values; this is not a comprehensive list.
2022.1
C2022.1
SNFPR22.1

COMMENT: This field is not populated prior to 2021.

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CLM_RLT_COND_CD

LABEL: Claim Related Condition Code

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

SHORT NAME: RLT_COND

LONG NAME: CLM_RLT_COND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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CLM_RLT_OCRNC_CD

LABEL: Claim Related Occurrence Code

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

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

SHORT NAME: OCRNC_CD

LONG NAME: CLM_RLT_OCRNC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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CLM_RLT_OCRNC_DT

LABEL: Claim Related Occurrence Date

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

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

SHORT NAME: OCRNCDT

LONG NAME: CLM_RLT_OCRNC_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_RP_IND_CD

LABEL: Claim Representative Payee (RP) Indicator Code

DESCRIPTION: Claim representative payee (RP) indicator code.

SHORT NAME: CLM_RP_IND_CD

LONG NAME: CLM_RP_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: R = bypass representative payee
Null/missing = not applicable

COMMENT: This field is used to designate by-passing of the prior authorization processing for claims with a representative payee when an "R" is present in the field.

This field was added in April 2018.

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CLM_RSDL_PYMT_IND_CD

LABEL: Claim Residual Payment Indicator Code

DESCRIPTION: Claim residual payment indicator code.

SHORT NAME: CLM_RSDL_PYMT_IND_CD

LONG NAME: CLM_RSDL_PYMT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: X = Residual payment
Null/missing = not applicable

COMMENT: This field is used by CWF claims processing for the purpose of bypassing its normal MSP editing that would otherwise apply for ongoing responsibility for medicals (ORM) or worker's compensation Medicare Set-Aside Arrangements (WCMSA). Normally, CWF does not allow a secondary payment on MSP involving ORM or WCMSA, so the residual payment indicator will be used to allow CWF to make an exception to its normal routine.

This field appears in the data starting April 2008.

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CLM_SITE_NTRL_PYMT_CST_AMT

LABEL: Claim Site Neutral Payment Based on Cost Amount

DESCRIPTION: Under the long-term care hospital (LTCH) prospective payment system (PPS), the payment amount based on estimated cost of the case.

SHORT NAME: CLM_SITE_NTRL_PYMT_CST_AMT

LONG NAME: CLM_SITE_NTRL_PYMT_CST_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

For a LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the four fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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CLM_SITE_NTRL_PYMT_IPPS_AMT

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

DESCRIPTION: Under the long-term care hospital (LTCH) prospective payment system (PPS), the payment amount based on the inpatient prospective payment system (IPPS) comparable amount. This amount does not include any applicable outlier payment amount.

SHORT NAME: CLM_SITE_NTRL_PYMT_IPPS_AMT

LONG NAME: CLM_SITE_NTRL_PYMT_IPPS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

For a LTCH PPS

claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT,

CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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CLM_SPAN_CD

LABEL: Claim Occurrence Span Code

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

These codes are claim-related occurrences that are related to a time period span of dates (variables called the CLM_SPAN_FROM_DT and CLM_SPAN_THRU_DT).

SHORT NAME: SPAN_CD

LONG NAME: CLM_SPAN_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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CLM_SPAN_FROM_DT

LABEL: Claim Occurrence Span From Date

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

The first date associated with the claim occurrence span code (variable called the CLM_SPAN_CD).

SHORT NAME: SPANFROM

LONG NAME: CLM_SPAN_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_SPAN_THRU_DT

LABEL: Claim Occurrence Span Through Date

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

The last date associated with the claim occurrence span code (variable called the CLM_SPAN_CD).

SHORT NAME: SPANTHRU

LONG NAME: CLM_SPAN_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_SRC_IP_ADMSN_CD

LABEL: Claim Source Inpatient Admission Code

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

SHORT NAME: SRC_ADMS

LONG NAME: CLM_SRC_IP_ADMSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

^ Back to TOC ^

CLM_SRVC_CLSFCTN_TYPE_CD

LABEL: Claim Service Classification Type Code

DESCRIPTION: The type of service provided to the beneficiary.

SHORT NAME: TYPESRVC

LONG NAME: CLM_SRVC_CLSFCTN_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

For facility type code 7 (clinics):

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

For facility type code 8 (special facility):

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center (ASC) in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access hospital — outpatient services
7 = Freestanding Non-residential Opioid Treatment Programs (eff. 1/2021)

COMMENT: This field, in combination with the facility type code (variable called CLM_FAC_TYPE_CD) indicates the "type of bill" for an institutional claim. Many different types of services can be billed on a Part A or Part B institutional claim and knowing the type of bill helps to distinguish them. The type of bill is the concatenation of two variables: the facility type (CLM_FAC_TYPE_CD) and the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD).

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CLM_SRVC_FAC_ZIP_CD

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

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

SHORT NAME: CLM_SRVC_FAC_ZIP_CD

LONG NAME: CLM_SRVC_FAC_ZIP_CD

TYPE: CHAR

LENGTH: 9

SOURCE: NCH

VALUES: XXXXXXXXX

COMMENT: —

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CLM_SS_OUTLIER_STD_PYMT_AMT

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

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

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

SHORT NAME: CLM_SS_OUTLIER_STD_PYMT_AMT

LONG NAME: CLM_SS_OUTLIER_STD_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

For a LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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CLM_THRU_DT

LABEL: Claim Through Date

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

SHORT NAME: THRU_DT

LONG NAME: CLM_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: For home health prospective payment system (PPS) claims, the “from” date and the “thru” date on the RAP (Request for Anticipated Payment) initial claim match.

The "thru" date on the claim may not always represent the last date of services, particularly for home health or hospice care. To obtain the date corresponding with the cessation of services (or discharge date) use the discharge date from the claim (variable called NCH_BENE_DSCHRG_DT; **NOTE:** this variable is not available for home health claims).

For Part B non-institutional (carrier and DME) services, this variable corresponds with the latest of any of the line-item level dates (i.e., in the Line File, it is the last CLM_THRU_DT for any line on the claim). It is almost always the same as the CLM_FROM_DT; exception is for DME claims — where some services are billed in advance. In instances where the year of the claim through date was greater than the year of the data file, the CCW team derived the CLM_THRU_DT to be 12/31 of the data year.

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CLM_TOT_CHRG_AMT

LABEL: Claim Total Charge Amount

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

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

SHORT NAME: TOT_CHRG

LONG NAME: CLM_TOT_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CLM_TOT_PPS_CPTL_AMT

LABEL: Claim Total PPS Capital Amount

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

This is the sum of the capital hospital specific portion, federal specific portion, outlier portion, disproportionate share portion, indirect medical education portion, exception payments, and hold harmless payments.

SHORT NAME: PPS_CPTL

LONG NAME: CLM_TOT_PPS_CPTL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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CLM_TRTMT_AUTHRZTN_NUM

LABEL: Claim Treatment Authorization Number

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

SHORT NAME: CLM_TRTMT_AUTHRZTN_NUM

LONG NAME: CLM_TRTMT_AUTHRZTN_NUM

TYPE: CHAR

LENGTH: 18

SOURCE: NCH

VALUES: XXXXXXX

COMMENT: This number is used by the fiscal intermediary and the Peer Review Organization.

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CLM_UNCOMPD_CARE_PMT_AMT

LABEL: Claim Uncompensated Care Payment Amount

DESCRIPTION: This field identifies the payment for disproportionate share hospitals (DSH). It represents the uncompensated care amount of the payment.

SHORT NAME: CLM_UNCOMPD_CARE_PMT_AMT

LONG NAME: CLM_UNCOMPD_CARE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field applies only to inpatient claims.

These payments were authorized as part of Section 3133 of the Affordable Care Act (ACA).

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CLM_UTLZTN_DAY_CNT

LABEL: Claim Medicare Utilization Day Count

DESCRIPTION: On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days.

It excludes any days classified as non-covered, leave of absence days, and the day of discharge or death.

SHORT NAME: UTIL_DAY

LONG NAME: CLM_UTLZTN_DAY_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_VAL_AMT

LABEL: Claim Value Amount

DESCRIPTION: The amount related to the condition identified in the claim value code (variable called CLM_VAL_CD) which was used by the intermediary to process the institutional claim.

SHORT NAME: VAL_AMT

LONG NAME: CLM_VAL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CLM_VAL_CD

LABEL: Claim Value Code

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

The associated monetary value is in the claim value amount field (CLM_VAL_AMT).

SHORT NAME: VAL_CD

LONG NAME: CLM_VAL_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC) https://www.nubc.org/

COMMENT: —

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CLM_VBP_ADJSTMT_PCT

LABEL: Claim VBP Adjustment Percent

DESCRIPTION: Under the Hospital Value Based Purchasing (HVBP) program, an adjustment is made to the base operating DRG amount for certain inpatient prospective payment system (IPPS) hospitals — based on their total performance score (TPS).

SHORT NAME: CLM_VBP_ADJSTMT_PCT

LONG NAME: CLM_VBP_ADJSTMT_PCT

TYPE: NUM

LENGTH: 15

SOURCE: NCH

VALUES: X.XX

COMMENT: This initiative began in fourth quarter of 2013 (i.e., beginning of federal fiscal year 14 [FY14]).

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

The HVBP applies only to subsection (d) IPPS hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (reference CLM_VBP_PRTCPNT_IND_CD). This percentage reduction is applied to the base operating DRG amount, depending on their TPS (which is the Value Based Purchasing Score), as required by the Affordable Care Act (ACA). The percentages change each FY.

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

The actual dollar amount of the adjustment that applied to the claim is found in the variable called CLM_VBP_ADJSTMT_PMT_AMT.

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CLM_VBP_ADJSTMT_PMT_AMT

LABEL: Claim Value-Based Purchasing Adjustment Payment Amount

DESCRIPTION: This field represents the Hospital Value Based Purchasing (HVBP) amount.

This could be an additional payment on the claim or a reduction, depending on the hospital's performance score.

SHORT NAME: CLM_VBP_ADJSTMT_PMT_AMT

LONG NAME: CLM_VBP_ADJSTMT_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX (may be a negative value)

COMMENT: This initiative began in fourth quarter of 2013 (i.e., beginning of federal fiscal year 14 [FY14]). This field was new in 2013 and is null/missing for all previous years.

The HVBP applies only to subsection (d) inpatient prospective payment system (IPPS) hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (reference CLM_VBP_PRTCPNT_IND_CD).

This amount is based on a VBP adjustment percent (variable called CLM_VBP_ADJSTMT_PCT) that is applied to the base operating DRG amount, depending on the hospital's Total Performance Score (TPS), which is the Value Based Purchasing Score.

HVBP is required by the Affordable Care Act (ACA). The percentages change each FY. Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

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CLM_VBP_PRTCPNT_IND_CD

LABEL: Claim Value-Based Purchasing (VBP) Participant Indicator Code

DESCRIPTION: This field is the code used to identify a reason a hospital is excluded from the Hospital Value Based Purchasing (HVBP) program.

SHORT NAME: CLM_VBP_PRTCPNT_IND_CD

LONG NAME: CLM_VBP_PRTCPNT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Participating in Hospital Value Based Purchasing
N = Not participating in Hospital Value Based Purchasing
Null/missing = same as “N”

COMMENT: The ACA (Section 3001) excludes from the HVBP hospitals that meet certain conditions. Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

This initiative began in fourth quarter of 2013 (i.e., beginning of federal fiscal year 14).

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

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CPO_ORG_NPI_NUM

LABEL: CPO Organization NPI Number

DESCRIPTION: The National Provider Identifier (NPI) number of the home health agency (HHA) or hospice rendering Medicare services during the period the physician is providing care plan oversight (CPO).

SHORT NAME: CPO_ORG_NPI_NUM

LONG NAME: CPO_ORG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.

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CPO_PRVDR_NUM

LABEL: Care Plan Oversight (CPO) Provider Number

DESCRIPTION: The National Provider Identifier (NPI) number of the home health agency (HHA) or hospice rendering Medicare services during the period the physician is providing care plan oversight (CPO).

SHORT NAME: CPO_PRVDR_NUM

LONG NAME: CPO_PRVDR_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.

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DEMO_ID_NUM

LABEL: Demonstration number

DESCRIPTION: The number assigned to identify a CMS demonstration project.

This field is also used to denote special processing (a.k.a. special processing number, SPN).

SHORT NAME: DEMO_ID_NUM

LONG NAME: DEMO_ID_NUM

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

01 = Nursing Home Case-Mix and Quality Demo (retired)
02 = National HHA Prospective Payment Demo
03 = Telemedicine Waiver Demo (retired)
04 = United Mine Workers of America (UMWA) Managed Care Demo
05 = Medicare Choices (MCO encounter data) demo
06 = Medicare Participating Heart Bypass Center Demo
07 = Participating Centers of Excellence (retired)
08 = Provider Partnership Demo (retired) 09 = Colorado Integrated Care and Financing Project
10 = Community Nursing Organization Demo
11 = Consumer Directed DME Demo
12 = Competitive Bidding for Clinical Labs (non-MMA demo)
13 = Competitive Bidding for DME Demo
14 = Competitive Pricing — open enrollment demo (non-MMA)
15 = ESRD Managed Care (MCO encounter data) demo (retired
16 = Utah All Payer Graduate Medical Education demo
17 = Group Specific Volume Performance Standards
19 = Medicaid Working Group Dual eligibles
20 = Minnesota Senior Health options
21 = Municipal Health Services Program
22 = New England Dual Eligible Waiver Project
23 = PACE
24 = Seattle Outlier Pool
25 = SHMO II
26 = VA Medicare Subvention Demo
27 = Wisconsin Partnership Demo
29 = On Lok
30 = Lung Volume Reduction (NIH Clinical Trial) non-demo
31 = VA Pricing — not a demo
32 = DoD Medicare Subvention Demo
33 = Medical Savings Account (BBA)
34 = New York Continuing Care Networks (aka Rochester and Monroe County)
35 = Evercare Managed Care for Nursing Home Residents
36 = SHMO I
37 = Coordinated Care Demonstration (BBA)
38 = Encounter Data (not a demo)
39 = Flu/Pneumonia vaccinations Encounter Data

40 = Payment of Physician and Non-physician Services in certain Indian Providers (Rhem Gray)
42 = ESRD DM — basic ESRD demo bundle
43 = ESRD DM — expanded ESRD demo bundle including venous access procedures
44 = Homebound demo (MMA)
45 = Chiropractic (MMA)
46 = Vision Rehab (2004 appropriation project)
47 = Flu Medication Demo
48 = Home health Adult Day-Care (s. 703 of MMA)
49 = Frequent Hemodialysis Network Clinical Trial
50 = Anti-Cancer Colorectal Drugs during Clinical Trials
51 = Clinical Lab Competitive Bidding (MMA) (retired)
52 = Inhalation Therapy (retired)
53 = Frontier Extended Stay Clinic
54 = ACE Demo (retired)
55 = Avastin Lucentis Clinical trial
56 = Section 3113 ACA Lab Demo (retired)
57 = Medicaid Emergency Psych — section 2707 ACA
58 = Multi-payer Advanced Primary Care Practice (MAPCP) CMMI
59 = Pioneer ACO Model (CMI)
60 = Medicare Pre-Payment Review and Prior Authorization of Power Mobility Devices Demonstration (OFM) (retired 1/2023)
61 = Bundled Payments for Care Improvement model 1 (CMMI)
62 = Bundled Payments for Care Improvement model 2
63 = Bundled Payments for Care Improvement model 3
64 = Bundled Payments for Care Improvement model 4
65 = A/B Rebilling Demonstration — rebilled claims due to auditor denials (OFM) (retired 1/2023)
66 = A/B Rebilling Demonstration — rebilled claims due to provider self-audit after claims submission/payment (retired 1/2023)
67 = A/B Rebilling Demonstration — rebilled claims due to provider self-audit after the patient has been discharged but prior to payment (retired 1/2023)
68 = SNF Qualifying Stay — Pioneer ACO
69 = Advance Payment ACO Model
70 = Electrical Workers Insurance Fund claims (EWIF)
71 = IVIG (Intravenous Immunoglobulin) Demo (retired)
72 =Implementing Payment Changes for home health Travel Reimbursement Changes for FCHIP (retired)
73 = Medicare Care Choices Model (retired)
74 = Next Generation ACO Model (retired)
75 = Coordinated Quality Care — Comprehensive Care for Joint replacement (CCJR)
76 = Million Hearts CVD Risk Reduction Model (retired)
77 = Shared Savings Program (used in FISS and CWF to bypass the SNF 3-day requirement)78 = Comprehensive Primary Care Plus (CPC+) Model — MCS analysis
79 = Acute Myocardial Infarction (AMI) Episode Payment Model (EPM) (cancelled)
80 = Coronary Artery Bypass Graft (CABG) Episode Payment Model (EPM) (cancelled)
81 = Surgical Hip and Femur Fracture Treatment (SHFFT) Episode Payment Model (EMP) (cancelled)
82 = Medicare Diabetes Prevention Program (MDPP)
83 = Maryland Primary Care Program (MDPCP) Federally Qualified Health Center (FQHC) (eff. 1/2022). Previously was Maryland All Payer Model. This is the 3rd iteration of the Maryland All-Payer Model. This latest iteration encompasses Maryland Primary Care Program (MDPCP)

84 = Diabetes Prevention Program Virtual Model Test
85 = Comprehensive ESRD Care (CEC) Model (retired)
86 = Bundled Payments for Care Improvement (BPCI) — Advanced
87 = Radiation Oncology Bundled Payments (cancelled)
88 = Shared Savings Program (TELEHEALTH waiver)
89 = Vermont all-payer (VT ACO model)
91 = Emergency Triage, Treat and Transport (ET3) (retired)
92 = Direct Contracting (DC) Model/ ACO reach (delete)
93 = Comprehensive Kidney Care Contracting (CKCC)
94 = ESRD Treatment Choices (ETC)
95 = Oncology Care Model Plus (OCM+) (retired)
96 = Primary Care First (PCF) Seriously Ill Population (SIP) Model
97 = Kidney Care First (KCF)
98 = The Pennsylvania Rural Health Model (PARHM) (termination date 12/31/2026)
99 = Opioid Use Disorder (OUD) Treatment Demonstration Program
A1 = Direct contracting (GEO)
A2 = Community Health Access and Rural Transformation Model (CHART)
A3 = Enhancing Oncology Model
A4 = Maryland Total Cost of Care Model
A5 = Making Care Primary (MCP) claims
A6= Guiding an Improved Dementia Experience
A7 = States Advancing All-payer Health Equity Approaches and Development

COMMENT: —

^ Back to TOC ^

DEMO_ID_SQNC_NUM

LABEL: Demonstration sequence number

DESCRIPTION: The number of demonstration identification trailers present on the claim.

SHORT NAME: DEMO_ID_SQNC_NUM

LONG NAME: DEMO_ID_SQNC_NUM

TYPE: NUM

LENGTH: 3

SOURCE: CCW

VALUES: —

COMMENT: The demonstration sequence number is a sequential line number to distinguish distinct demonstration projects that affect the same claim.

^ Back to TOC ^

DEMO_INFO_TXT

LABEL: Demonstration information text

DESCRIPTION: This is a text field that contains information related to the demonstration.

For example, a claim involving a CHOICES demo id “05” would contain the MCO plan contract number in the first five positions of this text field.

SHORT NAME: DEMO_INFO_TXT

LONG NAME: DEMO_INFO_TXT

TYPE: CHAR

LENGTH: 15

SOURCE: NCH

VALUES: —

COMMENT: When the Demo ID = 01 (RUGS) — the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect “INVALID”. **NOTE:** In version “G”, RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (home health demo) — the text field will contain PROV#. When demo number not equal to 02 then text will reflect “INVALID”

Demo ID = 03 (Telemedicine demo) — text field will contain the HCPCS code. If the required HCPCS is not shown, then the text field will reflect “INVALID”

Demo ID = 04 (UMWA) — text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present, then the text field will reflect “INVALID”

Demo ID = 05 (CHOICES) — the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or inpatient claim shows that 1st 3 positions of provider number as “210” and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect “INVALID CHOICES PLAN NUMBER”. When CHOICES plan number not present, text will reflect “INVALID”

Demo ID = 15 (ESRD Managed Care) — text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number does not present the field will reflect “INVALID”

Demo ID = 38 (Physician Encounter Claims) — text field will contain the MCO plan number. When MCO plan number is not present the field will reflect “INVALID”

^ Back to TOC ^

DMERC_LINE_FRGN_ADR_IND

LABEL: Line Foreign Address Indicator

DESCRIPTION: Line Foreign Address Indicator on the durable medical equipment (DME) claim line

SHORT NAME: DMERC_LINE_FRGN_ADR_IND

LONG NAME: DMERC_LINE_FRGN_ADR_IND

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: EX = Expatriate Beneficiary

COMMENT: This field is used to identify claims for expatriate beneficiaries (beneficiary whose permanent address is outside the U.S.) who purchased DMEPOS items that were furnished in the United States.

This field was new in July 2016.

^ Back to TOC ^

DMERC_LINE_MTUS_CD

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

DESCRIPTION: Code indicating the units associated with services needing unit reporting on the line item for the DMERC service.

SHORT NAME: UNIT_IND

LONG NAME: DMERC_LINE_MTUS_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
0 = Values reported as zero
1 = (rarely used)
2 = (rarely used)
3 = Number of services
4 = Oxygen volume units
6 = Drug dosage (valid 2004 and earlier) — since early 1994 this value has incorrectly been placed on DMERC claims. The DMERCs were overriding the MTUS indicator with a "6" if the claim was submitted with an NDC code.

NOTE: This problem has been corrected — no date on when the correction became effective.

COMMENT: —

^ Back to TOC ^

DMERC_LINE_MTUS_CNT

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

DESCRIPTION: The count of the total units associated with services needing unit reporting such as number of supplies, volume of oxygen or nutritional units.

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

SHORT NAME: DME_UNIT

LONG NAME: DMERC_LINE_MTUS_CNT

TYPE: NUM

LENGTH: 11

SOURCE: NCH

VALUES: —

COMMENT: Prior to version "J," this field was S9(3)

^ Back to TOC ^

DMERC_LINE_PRCNG_STATE_CD

LABEL: DMERC Line Pricing State Code (SSA)

DESCRIPTION: The 2-digit SSA state code where the durable medical equipment (DME) supplier was located; used by the Medicare Administrative Contractor (MAC) for pricing the service.

SHORT NAME: PRCNG_ST

LONG NAME: DMERC_LINE_PRCNG_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada and Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa

65 = Guam
97 = Northern Marianas
98 = Guam
99 = Unknown or if county code = 000 then this is American Samoa

COMMENT: —

^ Back to TOC ^

DMERC_LINE_SCRN_SVGS_AMT

LABEL: DMERC Line Screen Savings Amount

DESCRIPTION: The amount of savings attributable to the coverage screen for this DMERC line item.

SHORT NAME: SCRNSVGS

LONG NAME: DMERC_LINE_SCRN_SVGS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

^ Back to TOC ^

DMERC_LINE_SUPPLR_TYPE_CD

LABEL: DMERC Line Supplier Type Code

DESCRIPTION: The type of DMERC supplier.

SHORT NAME: SUP_TYPE

LONG NAME: DMERC_LINE_SUPPLR_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.

1 = Physicians or suppliers billing as solo practitioners for whom SSNs are shown in the physician ID code field.

2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.

3 = Suppliers (other than sole proprietorship) for whom employer identification (EI) numbers are used in coding the ID field.

4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.

5 = Institutional providers and independent laboratories for whom employer identification (EI) numbers are used in coding the ID field.

6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.

7 = Clinics, groups, associations, or partnerships for whom employer identification (EI) numbers are used in coding the ID field.

8 = Other entities for whom employer identification (EI) numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

COMMENT: —

^ Back to TOC ^

DMERC_OXGN_EQUIP_INITL_DT

LABEL: Oxygen Equipment Initial Date

DESCRIPTION: The initial date for oxygen equipment.

SHORT NAME: DMERC_OXGN_EQUIP_INITL_DT

LONG NAME: DMERC_OXGN_EQUIP_INITL_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated before 2023. This is to support the elimination of the Certificate of Medical Necessity (CMN).

^ Back to TOC ^

DMERC_OXGN_EQUIP_PRVS_DT

LABEL: Oxygen Equipment Previous Date

DESCRIPTION: The previous date for oxygen equipment. This date applies to claim lines that have a backdated initial date indicator (DMERC_OXGN_INITL_DT_CD = B).

SHORT NAME: DMERC_OXGN_EQUIP_PRVS_DT

LONG NAME: DMERC_OXGN_EQUIP_PRVS_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated before 2023. This is to support the elimination of the Certificate of Medical Necessity (CMN).

^ Back to TOC ^

DMERC_OXGN_INITL_DT_CD

LABEL: Oxygen Equipment Initial Date Code

DESCRIPTION: The initial date indicator for oxygen equipment.

SHORT NAME: DMERC_OXGN_INITL_DT_CD

LONG NAME: DMERC_OXGN_INITL_DT_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: I = Initial Date
B = Backdate Initial Date
R = Replacement Item
Null/missing = no oxygen equipment

COMMENT: This field is not populated before 2023. This is to support the elimination of the Certificate of Medical Necessity (CMN).

^ Back to TOC ^

DOB_DT

LABEL: Date of Birth from Claim

DESCRIPTION: The beneficiary's date of birth.

SHORT NAME: DOB_DT

LONG NAME: DOB_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

DSH_OP_CLM_VAL_AMT

LABEL: Operating Disproportionate Share (DSH) Amount

DESCRIPTION: This is one component of the total amount that is payable on prospective payment system (PPS) claims and reflects the DSH (disproportionate share hospital) payments for operating expenses (such as labor) for the claim.

There are two types of DSH amounts that may be payable for many PPS claims; the other type of DSH payment is for the DSH capital amount (variable called CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT).

Both operating and capital DSH payments are components of the PPS, as well as numerous other factors.

SHORT NAME: DSH_OP

LONG NAME: DSH_OP_CLM_VAL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

DERIVATION RULES: If there is a value code “18” (i.e., in the value code file, if the VAL_CD=“18”) then this dollar amount (VAL_AMT) is used to populate this field."

^ Back to TOC ^

EHR_PGM_RDCTN_IND_SW

LABEL: Claim Electronic Health Records (EHR) Program Reduction Indicator Switch

DESCRIPTION: This field is a switch that identifies which hospitals are Electronic Health Records (EHR) meaningful users and distinguishes hospitals that will have a payment penalty for not being meaningful users.

SHORT NAME: EHR_PGM_RDCTN_IND_SW

LONG NAME: EHR_PGM_RDCTN_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = hospital is subject to a reduction under the EHR program

Blank = not applicable

COMMENT: This field is new in October 2014. This field only applies to inpatient claims.

^ Back to TOC ^

EHR_PYMT_ADJSTMT_AMT

LABEL: Claim Electronic Health Record (EHR) Payment Adjustment Amount

DESCRIPTION: The claims adjustment payment amount for Hospitals that are not meaningful users of certified Electronic Health Record (EHR) technology.

SHORT NAME: EHR_PYMT_ADJSTMT_AMT

LONG NAME: EHR_PYMT_ADJSTMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

^ Back to TOC ^

ESRD_TRTMT_CHS_IND_CD

LABEL: End-Stage Renal Disease (ESRD) Treatment Choices Demonstration Indicator Code

DESCRIPTION: The type of ESRD treatment Choices (ETC) Model (Demo code 94).

SHORT NAME: ESRD_TRTMT_CHS_IND_CD

LONG NAME: ESRD_TRTMT_CHS_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: H or blank = Home Dialysis Payment Adjustment (HDPA) only
P = Performance Payment Adjustment (PPA) only
B = HDPA and PPA

COMMENT: The two types are, Home Dialysis Payment Adjustment (HDPA) and Performance Payment Adjustment (PPA). This field is not populated prior to 2021.

^ Back to TOC ^

FI_CLM_ACTN_CD

LABEL: FI or MAC Claim Action Code

DESCRIPTION: The type of action requested by the intermediary to be taken on an institutional claim.

SHORT NAME: ACTIONCD

LONG NAME: FI_CLM_ACTN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = Original debit action (always a 1 for all regular bills)
5 = Force action code 3 (secondary debit adjustment)
8 = Benefits refused

COMMENT: —

^ Back to TOC ^

FI_CLM_PROC_DT

LABEL: FI Claim Process Date

DESCRIPTION: The date the fiscal intermediary completes processing and releases the institutional claim to the CMS common working file (CWF; stored in the NCH).

SHORT NAME: FI_CLM_PROC_DT

LONG NAME: FI_CLM_PROC_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

FI_NUM

LABEL: FI or MAC Number

DESCRIPTION: The identification number assigned by CMS to a fiscal intermediary (FI) authorized to process institutional claim records.

Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

SHORT NAME: FI_NUM

LONG NAME: FI_NUM

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: Different FI/MAC carriers are under contract with CMS at different times.

Reference the CMS website for MAC Contract Status (for example):
https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/who-are-the-macs#MapsandLists

Fiscal Intermediary Numbers (as of October 2021):

00010 Alabama BC — Alabama (term. 05/2009)(replaced with MAC #10101)
00011 Alabama BC — Iowa (term. 10/2007) replaced by MAC # 03401)
00011 Cahaba — (RHHI) (term. 06/2011) replaced by MAC # 03401)
00012 Iowa (terminated) replaced by MAC # 05101)
00012 Arizona — Noridian — J3 A MAC (AZA)(term. 05/2008)
00020 Arkansas BC — Arkansas
00021 Arkansas BC — Rhode Island(term. 05/2009)
00030 Arizona BC (term. 09/2007)(replaced by MAC # 03101)
00040 California BC (term. 11/2000)
00090 Florida BC (term. 02/2009)(replaced with MAC #09101)
00101 Georgia BC (term. 05/2009)(replaced with MAC #10201)
00130 Indiana BC/Administer Federal (term. 7/22/2012)(replaced with MAC # 08101)
00131 Illinois — Anthem
00140 Iowa — Wellmark (term. 05/2000)
00150 Kansas BC (term. 02/2008)(replaced with MAC # 05201)
00160 Kentucky — Anthem (term. 4/30/2011)(replaced with MAC # 15101)
00180 Maine BC (term. 05/2009)(replaced with MAC #14004 and 14101)
00180 Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island (Maine RHHI)(term. 05/2009)(replaced with MAC #14004 and 14101)
00181 Massachusetts — Maine BC (term. 05/2009)
00190 Carefirst of Maryland (term. 09/2005)
00230 Mississippi BC

00230 Trispan Health Services (LA-MS) (term. 09/2009)(previously also MOA)
00242 BCBS of MS (MOA) (term. 04/2008)(replaced with MAC # 05301)
00242 Missouri (terminated)(replaced with MAC # 05301)
00250 Montana BC (term. 11/2006)(replaced by MAC # 03201)
00260 Nebraska BC (term. 11/2007)(replaced with MAC # 05401)
00270 New Hampshire BC — New Hampshire, Vermont (term. 06/2009)(replaced with MAC #14501)
00280 New Jersey BC (term. 07/2000)
00308 Empire BC — New York, Connecticut, and Delaware (term. 11/2008)(replaced with MAC # 12101, 13201 and 13101)
00310 North Carolina BC (term. 09/2002)
00320 North Dakota BC — North Dakota (term. 12/1/2006)(replaced with MAC # 03301)
00322 North Dakota BC — Washington and Alaska
00323 North Dakota BC — Idaho, Oregon, and Utah (term. 11/2006)(replaced with MAC # 03501)
00325 Noridian — Idaho, Oregon
00332 Administar — Ohio Anthem — Ohio
00340 Oklahoma BC (term. 02/2008)(replaced with MAC # 04301)
00350 Regence — Oregon, Idaho, Utah (term. 11/2005)
00363 Pennsylvania/Highmark — Veritus (term. 07/2008)
00366 Highmark (MD and DC) — Part A (eff. 10/2005)(term. 07/2008)
00370 Rhode Island BC (term. 03/2004)(replaced with MAC #14401)
00380 South Carolina BC — South Carolina (term. 01/2011)(replaced with MAC #11004 and 11201)
00380 Palmetto GBA — AL, AR, GA, FL, IL, IN, KY, LA, MS, MN, NC, OK, OH, SC, TN, TX (term. 01/2011)
00382 South Carolina BC — North Carolina (term. 10/2010)(replaced with MAC #11501)
00390 Riverbend BC — New Jersey, Tennessee (term. 08/2009)(replaced with MAC # 12001 and 10301)
00400 Texas BC — Colorado, New Mexico, Texas (term. 05/2008)(replaced with MAC #04101, 04201, 04401 — refer below)
00410 Utah BC (term. 09/2000)
00430 Premera BC — Washington, Alaska(term. 09/2004)
00450 Wisconsin BC — Wisconsin
00450 Michigan, Minnesota, New Jersey, New York, Wisconsin (RHHI)
00452 Wisconsin BC — Michigan (term. 7/22/2012)(replaced with MAC # 08201)
00453 Wisconsin BC — Virginia and West Virginia(term. 05/2011)(replaced with MAC #11301 and 11401)
00454 Wisconsin BC — California, Hawaii, Nevada (RHHI)(term. 08/2008)(replaced by MAC #01101, 01201 and 01301 — refer below)
00460 Wyoming BC (term. 10/2006)(replaced by MAC # 03601)
00468 North Carolina BC/CPRTIVA (terminated)
01101 California (eff. 8/15/2008)(replaces FI #00454)
01111 California entire state — Noridian Healthcare Solutions
01201 Hawaii (eff. 8/15/2008)(replaces FI #00454)
01211 Guam, Hawaii, Northern Mariana Islands — Noridian Healthcare Solutions
01301 Nevada (eff. 8/15/2008)(replaces FI #00454)
01311 Nevada — Noridian Healthcare Solutions
01390 AETNA — Washington
01911 American Samoa, California — entire state, Guam, Hawaii, Nevada, Northern Mariana Islands — Noridian Healthcare Solutions
02101 Alaska (eff. 02/01/2012)

02201 Idaho (eff. 02/01/2012)
02301 Oregon (eff. 02/01/2012)
02401 Washington (eff. 02/01/2012)
03001 JF Roll-up (2/3)(Orig. J3 term. 09/2007)
03101 Arizona (eff. 10/1/2007)(replaces FI #00030)
03201 Montana (eff. 12/1/2006)(replaces FI #00250)
03301 North Dakota (eff. 12/1/2006)(replaces FI #00320)
03401 South Dakota (eff. 3/1/2007)(replaces FI #00011)
03501 Utah (eff. 12/1/2006)(replaces FI #00323)
03601 Wyoming (eff. 11/1/2006)(replaces FI #00460)
04101 Colorado (eff. 6/1/2008) (terminated)(replaces FI #00400)
04111 Colorado (eff. 10/29/2012)
04201 New Mexico (eff. 6/16/2008)(replaces FI #00400)
04211 New Mexico (eff. 10/29/2012)
04301 Oklahoma (eff. 3/1/2008)(replaces FI #00340)
04311 Oklahoma (eff. 10/29/2012)
04401 Texas (eff. 6/16/2008)(replaces FI #00400)
04411 Texas (eff. 10/29/2012)
04911 WPS (Mutual of Omaha Legacy)(eff. 10/29/2012)
05101 Iowa (eff. 5/1/2008)(replaces FI #00012)
05201 Kansas (eff. 03/01/2008)(replaces FI #00150)
05301 West Missouri (eff. 5/1/2008)(replaces FI #00242)
05401 Physicians Service Insurance Corporation — Wisconsin
05901 Missouri-Entire state — Wisconsin Physicians Service Insurance Corporation
06001 J6 Roll-up
06014 RHHI Region D AK, AZ, CA, HI, ID, NV, OR, WA, American Samoa, Guam, and the Northern Marianas
06101 Illinois
06201 Minnesota
07101 Arkansas (eff. 08/20/2012)
07201 Louisiana (eff. 08/20/2012)
07301 Mississippi (eff. 08/20/2012)
08101 Indiana, WPS J8 (eff. 07/23/2012)
08201 Michigan, WPS J8(eff. 07/23/2012)
09101 Florida (eff. 2/13/2009)
09201 Puerto Rico (eff. 03/02/2009)
10111 Alabama — Palmetto GBA
10211 Georgia — Palmetto GBA
10311 Tennessee — Palmetto GBA
11004 Region C (HHH C RHHI) (eff. 1/24/2011)
11201 South Carolina (eff. 1/24/2011)
11301 Virginia (eff. 5/16/2011)
11401 West Virginia (eff. 5/16/2011)
11501 North Carolina (eff. 10/01/2010)
12101 Delaware (eff. 11/14/2008)(replaces FI # 00308)
12201 District of Columbia (eff. 08/01/2008)
12301 Maryland (eff. 08/01/2008)
12401 New Jersey (eff. 9/1/2008)(replaces FI # 00390)

12501 Pennsylvania (eff. 08/01/2008)
12901 Novitas Solutions J12
13101 Connecticut (eff. 8/1/2008)(replaces FI #00308)
13201 NGS-New York (eff. 7/18/2008)(replaces FI #00308)
14014 Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont – National Government Services, Inc
14111 Maine — National Government Services, Inc
14211 Massachusetts — National Government Services, Inc.
14311 New Hampshire — National Government Services, Inc.
14411 Rhode Island — National Government Services, Inc.
14511 Vermont — National Government Services, Inc
15004 CGS Government Services (HHH B RHHI)(eff. 06/13/2011)
15101 Kentucky (eff. 10/17/2011)
15201 Ohio (eff. 10/17/2011)
50333 Travelers; Connecticut United Healthcare(term. 07/2000)
52280 NE — Mutual of Omaha
52280 Mutual of Omaha (NT) Note: Nebraska — 00260 (NE) and 52280 (NT)

COMMENT: —

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FINL_STD_AMT

LABEL: Claim Final Standard Payment Amount

DESCRIPTION: This amount further adjusts the standard Medicare Payment amount (field called PPS_STD_VAL_PYMT_AMT) by applying additional standardization requirements (e.g., sequestration).

SHORT NAME: FINL_STD_AMT

LONG NAME: FINL_STD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XX.XX

COMMENT: This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard Medicare payment amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the hospitals.

This field first appeared in inpatient claims in October 2014. For HHA claims, this field first appeared in July 2018 and is called PPS_STD_VAL_PYMT_AMT.

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FST_DGNS_E_CD

LABEL: First Claim Diagnosis E Code

DESCRIPTION: The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.

SHORT NAME: FST_DGNS_E_CD

LONG NAME: FST_DGNS_E_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: Prior to version "J," this field was named: CLM_DGNS_E_CD.

Effective with version "J," this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

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

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FST_DGNS_E_VRSN_CD

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

DESCRIPTION: Effective with version "J," the code used to indicate if the diagnosis E code is ICD-9 or ICD-10.

SHORT NAME: FST_DGNS_E_VRSN_CD

LONG NAME: FST_DGNS_E_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: —

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

COMMENT: With 5010, the diagnosis and procedure codes were expanded to accommodate the future implementation of ICD-10.

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

^ Back to TOC ^

HAC_PGM_RDCTN_IND_SW

LABEL: Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Switch

DESCRIPTION: This field is a switch that identifies hospitals subject to a Hospital Acquired Conditions (HAC) reduction of what they would otherwise be paid under the inpatient prospective payment system (IPPS).

SHORT NAME: HAC_PGM_RDCTN_IND_SW

LONG NAME: HAC_PGM_RDCTN_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = hospital subject to a reduction under the HAC Reduction Program
N = hospital is not subject to a reduction under the HAC Reduction Program

COMMENT: This field is new in October 2014. This field only applies to inpatient claims.

For details on the CMS hospital readmission reduction program reference the CMS website: http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

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HCPCS_1ST_MDFR_CD

LABEL: HCPCS Initial Modifier Code

DESCRIPTION: A first modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to enable a more specific procedure identification for the revenue center or line-item service for the claim.

SHORT NAME: MDFR_CD1

LONG NAME: HCPCS_1ST_MDFR_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: —

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HCPCS_2ND_MDFR_CD

LABEL: HCPCS Second Modifier Code

DESCRIPTION: A second modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first modifier code to identify the revenue center or line-item service for the claim.

SHORT NAME: MDFR_CD2

LONG NAME: HCPCS_2ND_MDFR_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: —

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HCPCS_3RD_MDFR_CD

LABEL: HCPCS Third Modifier Code

DESCRIPTION: A third modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first or second modifier codes to identify the revenue center or line-item services for the claim.

SHORT NAME: MDFR_CD3

LONG NAME: HCPCS_3RD_MDFR_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: —

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HCPCS_4TH_MDFR_CD

LABEL: HCPCS Fourth Modifier Code

DESCRIPTION: A fourth modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first, second, or third modifier codes identify the revenue center or line-item services for the claim.

SHORT NAME: MDFR_CD4

LONG NAME: HCPCS_4TH_MDFR_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: This field is available only in the Hospital outpatient data file (no other claim types).

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HCPCS_CD

LABEL: Healthcare Common Procedure Coding System (HCPCS) Code

DESCRIPTION: The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products, and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below (in COMMENT).

In the Institutional Claim Revenue Center Files, this variable can indicate the specific case-mix grouping that Medicare used to pay for skilled nursing facility (SNF), home health, or inpatient rehabilitation facility (IRF) services (reference NOTE 2 in COMMENT section below).

SHORT NAME: HCPCS_CD

LONG NAME: HCPCS_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: Level I

Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5-position numeric codes representing physician and non-physician services.

NOTE 1: CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright.

Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Fifth Edition (CDT-5). These are five-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 five-position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in the level I or level II codes.

NOTE 2: This field may contain information regarding case-mix grouping that Medicare used to pay for SNF, home health, or IRF services. These groupings are sometimes known as Health Insurance prospective payment system (HIPPS) codes.

This field will contain a HIPPS code if the revenue center code (REV_CNTR) equals 0022 for SNF care, 0023 for home health, or 0024 for IRF care.

For home health claims, please also reference the revenue center APC/HIPPS code variable (REV_CNTR_APC_HIPPS_CD).

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HPSA_SCRCTY_IND_CD

LABEL: Carrier Line Health Professional Shortage Area (HPSA)/Scarcity Indicator Code

DESCRIPTION: The code used to track health professional shortage area (HPSA) and physician scarcity bonus payments on carrier claims.

SHORT NAME: HPSASCCD

LONG NAME: HPSA_SCRCTY_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
1 = HPSA
2 = Scarcity
3 = Both
5 =HPSA and HSIP
6 =PCIP
7 = HPSA and PCIP
Space = Not applicable

COMMENT: This variable was added 10/3/2005 with the implementation of NCH/NMUD CR#2.

Prior to 10/3/2005, claims contained a modifier code to indicate the bonus payment. A “QU” represented a HPSA bonus payment and an “AR” represented a scarcity bonus payment. As of 1/1/2005, the modifiers were no longer being reported by the provider. NCH and NMUD were not ready to accept the new field until 10/3/2005.

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ICD_DGNS_CD1
ICD_DGNS_CD2
ICD_DGNS_CD3
ICD_DGNS_CD4
ICD_DGNS_CD5
ICD_DGNS_CD6
ICD_DGNS_CD7
ICD_DGNS_CD8
ICD_DGNS_CD9
ICD_DGNS_CD10
ICD_DGNS_CD11
ICD_DGNS_CD12
ICD_DGNS_CD13
ICD_DGNS_CD14
ICD_DGNS_CD15
ICD_DGNS_CD16
ICD_DGNS_CD17
ICD_DGNS_CD18
ICD_DGNS_CD19
ICD_DGNS_CD20
ICD_DGNS_CD21
ICD_DGNS_CD22
ICD_DGNS_CD23
ICD_DGNS_CD24
ICD_DGNS_CD25

LABEL: Claim Diagnosis Code

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

SHORT NAME:

ICD_DGNS_CD1
ICD_DGNS_CD2
ICD_DGNS_CD3
ICD_DGNS_CD4
ICD_DGNS_CD5
ICD_DGNS_CD6
ICD_DGNS_CD7
ICD_DGNS_CD8
ICD_DGNS_CD9
ICD_DGNS_CD10
ICD_DGNS_CD11
ICD_DGNS_CD12
ICD_DGNS_CD13
ICD_DGNS_CD14
ICD_DGNS_CD15
ICD_DGNS_CD16
ICD_DGNS_CD17
ICD_DGNS_CD18
ICD_DGNS_CD19
ICD_DGNS_CD20
ICD_DGNS_CD21
ICD_DGNS_CD22
ICD_DGNS_CD23
ICD_DGNS_CD24
ICD_DGNS_CD25

LONG NAME:

ICD_DGNS_CD1
ICD_DGNS_CD2
ICD_DGNS_CD3
ICD_DGNS_CD4
ICD_DGNS_CD5
ICD_DGNS_CD6
ICD_DGNS_CD7
ICD_DGNS_CD8

ICD_DGNS_CD9
ICD_DGNS_CD10
ICD_DGNS_CD11
ICD_DGNS_CD12
ICD_DGNS_CD13
ICD_DGNS_CD14
ICD_DGNS_CD15
ICD_DGNS_CD16
ICD_DGNS_CD17
ICD_DGNS_CD18
ICD_DGNS_CD19
ICD_DGNS_CD20
ICD_DGNS_CD21
ICD_DGNS_CD22
ICD_DGNS_CD23
ICD_DGNS_CD24
ICD_DGNS_CD25

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: For ICD-9 diagnosis codes, this is a 3–5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015, the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

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

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ICD_DGNS_E_CD1

ICD_DGNS_E_CD2

ICD_DGNS_E_CD3

ICD_DGNS_E_CD4

ICD_DGNS_E_CD5

ICD_DGNS_E_CD6

ICD_DGNS_E_CD7

ICD_DGNS_E_CD8

ICD_DGNS_E_CD9

ICD_DGNS_E_CD10

ICD_DGNS_E_CD11

ICD_DGNS_E_CD12

LABEL: Claim Diagnosis E Code

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

SHORT NAME:

ICD_DGNS_E_CD1
ICD_DGNS_E_CD2
ICD_DGNS_E_CD3
ICD_DGNS_E_CD4
ICD_DGNS_E_CD5
ICD_DGNS_E_CD6
ICD_DGNS_E_CD7
ICD_DGNS_E_CD8
ICD_DGNS_E_CD9
ICD_DGNS_E_CD10
ICD_DGNS_E_CD11
ICD_DGNS_E_CD12

LONG NAME:

ICD_DGNS_E_CD1
ICD_DGNS_E_CD2
ICD_DGNS_E_CD3
ICD_DGNS_E_CD4
ICD_DGNS_E_CD5
ICD_DGNS_E_CD6
ICD_DGNS_E_CD7
ICD_DGNS_E_CD8
ICD_DGNS_E_CD9
ICD_DGNS_E_CD10
ICD_DGNS_E_CD11
ICD_DGNS_E_CD12

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: Effective with version "J," this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

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

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ICD_DGNS_VRSN_CD1

ICD_DGNS_VRSN_CD2

ICD_DGNS_VRSN_CD3

ICD_DGNS_VRSN_CD4

ICD_DGNS_VRSN_CD5

ICD_DGNS_VRSN_CD6

ICD_DGNS_VRSN_CD7

ICD_DGNS_VRSN_CD8

ICD_DGNS_VRSN_CD9

ICD_DGNS_VRSN_CD10

ICD_DGNS_VRSN_CD11

ICD_DGNS_VRSN_CD12

ICD_DGNS_VRSN_CD13

ICD_DGNS_VRSN_CD14

ICD_DGNS_VRSN_CD15

ICD_DGNS_VRSN_CD16

ICD_DGNS_VRSN_CD17

ICD_DGNS_VRSN_CD18

ICD_DGNS_VRSN_CD19

ICD_DGNS_VRSN_CD20

ICD_DGNS_VRSN_CD21

ICD_DGNS_VRSN_CD22

ICD_DGNS_VRSN_CD23

ICD_DGNS_VRSN_CD24

ICD_DGNS_VRSN_CD25

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

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

SHORT NAME:

ICD_DGNS_VRSN_CD1
ICD_DGNS_VRSN_CD2
ICD_DGNS_VRSN_CD3
ICD_DGNS_VRSN_CD4
ICD_DGNS_VRSN_CD5
ICD_DGNS_VRSN_CD6
ICD_DGNS_VRSN_CD7
ICD_DGNS_VRSN_CD8
ICD_DGNS_VRSN_CD9
ICD_DGNS_VRSN_CD10
ICD_DGNS_VRSN_CD11
ICD_DGNS_VRSN_CD12
ICD_DGNS_VRSN_CD13
ICD_DGNS_VRSN_CD14
ICD_DGNS_VRSN_CD15
ICD_DGNS_VRSN_CD16
ICD_DGNS_VRSN_CD17
ICD_DGNS_VRSN_CD18
ICD_DGNS_VRSN_CD19
ICD_DGNS_VRSN_CD20
ICD_DGNS_VRSN_CD21
ICD_DGNS_VRSN_CD22
ICD_DGNS_VRSN_CD23
ICD_DGNS_VRSN_CD24
ICD_DGNS_VRSN_CD25

LONG NAME:

ICD_DGNS_VRSN_CD1
ICD_DGNS_VRSN_CD2
ICD_DGNS_VRSN_CD3
ICD_DGNS_VRSN_CD4
ICD_DGNS_VRSN_CD5
ICD_DGNS_VRSN_CD6
ICD_DGNS_VRSN_CD7
ICD_DGNS_VRSN_CD8
ICD_DGNS_VRSN_CD9
ICD_DGNS_VRSN_CD10

ICD_DGNS_VRSN_CD11
ICD_DGNS_VRSN_CD12
ICD_DGNS_VRSN_CD13
ICD_DGNS_VRSN_CD14
ICD_DGNS_VRSN_CD15
ICD_DGNS_VRSN_CD16
ICD_DGNS_VRSN_CD17
ICD_DGNS_VRSN_CD18
ICD_DGNS_VRSN_CD19
ICD_DGNS_VRSN_CD20
ICD_DGNS_VRSN_CD21
ICD_DGNS_VRSN_CD22
ICD_DGNS_VRSN_CD23
ICD_DGNS_VRSN_CD24
ICD_DGNS_VRSN_CD25

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

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ICD_PRCDR_CD1
ICD_PRCDR_CD2
ICD_PRCDR_CD3
ICD_PRCDR_CD4
ICD_PRCDR_CD5
ICD_PRCDR_CD6
ICD_PRCDR_CD7
ICD_PRCDR_CD8
ICD_PRCDR_CD9
ICD_PRCDR_CD10
ICD_PRCDR_CD11
ICD_PRCDR_CD12
ICD_PRCDR_CD13
ICD_PRCDR_CD14
ICD_PRCDR_CD15
ICD_PRCDR_CD16
ICD_PRCDR_CD17
ICD_PRCDR_CD18
ICD_PRCDR_CD19
ICD_PRCDR_CD20
ICD_PRCDR_CD21
ICD_PRCDR_CD22
ICD_PRCDR_CD23
ICD_PRCDR_CD24
ICD_PRCDR_CD25

LABEL: Claim Procedure Code

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

SHORT NAME:

ICD_PRCDR_CD1
ICD_PRCDR_CD2
ICD_PRCDR_CD3
ICD_PRCDR_CD4
ICD_PRCDR_CD5
ICD_PRCDR_CD6
ICD_PRCDR_CD7
ICD_PRCDR_CD8
ICD_PRCDR_CD9
ICD_PRCDR_CD10
ICD_PRCDR_CD11
ICD_PRCDR_CD12
ICD_PRCDR_CD13
ICD_PRCDR_CD14
ICD_PRCDR_CD15
ICD_PRCDR_CD16
ICD_PRCDR_CD17
ICD_PRCDR_CD18
ICD_PRCDR_CD19
ICD_PRCDR_CD20
ICD_PRCDR_CD21
ICD_PRCDR_CD22
ICD_PRCDR_CD23
ICD_PRCDR_CD24
ICD_PRCDR_CD25

LONG NAME:

ICD_PRCDR_CD1
ICD_PRCDR_CD2
ICD_PRCDR_CD3
ICD_PRCDR_CD4
ICD_PRCDR_CD5
ICD_PRCDR_CD6
ICD_PRCDR_CD7
ICD_PRCDR_CD8
ICD_PRCDR_CD9
ICD_PRCDR_CD10

ICD_PRCDR_CD11
ICD_PRCDR_CD12
ICD_PRCDR_CD13
ICD_PRCDR_CD14
ICD_PRCDR_CD15
ICD_PRCDR_CD16
ICD_PRCDR_CD17
ICD_PRCDR_CD18
ICD_PRCDR_CD19
ICD_PRCDR_CD20
ICD_PRCDR_CD21
ICD_PRCDR_CD22
ICD_PRCDR_CD23
ICD_PRCDR_CD24
ICD_PRCDR_CD25

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on outpatient claims.

The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures.

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

ICD_PRCDR_CD1 is considered the primary procedure performed.

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ICD_PRCDR_VRSN_CD1

ICD_PRCDR_VRSN_CD2

ICD_PRCDR_VRSN_CD3

ICD_PRCDR_VRSN_CD4

ICD_PRCDR_VRSN_CD5

ICD_PRCDR_VRSN_CD6

ICD_PRCDR_VRSN_CD7

ICD_PRCDR_VRSN_CD8

ICD_PRCDR_VRSN_CD9

ICD_PRCDR_VRSN_CD10

ICD_PRCDR_VRSN_CD11

ICD_PRCDR_VRSN_CD12

ICD_PRCDR_VRSN_CD13

ICD_PRCDR_VRSN_CD14

ICD_PRCDR_VRSN_CD15

ICD_PRCDR_VRSN_CD16

ICD_PRCDR_VRSN_CD17

ICD_PRCDR_VRSN_CD18

ICD_PRCDR_VRSN_CD19

ICD_PRCDR_VRSN_CD20

ICD_PRCDR_VRSN_CD21

ICD_PRCDR_VRSN_CD22

ICD_PRCDR_VRSN_CD23

ICD_PRCDR_VRSN_CD24

ICD_PRCDR_VRSN_CD25

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

DESCRIPTION: The code used to indicate if the procedure code is ICD-9 or ICD-10.

SHORT NAME:

ICD_PRCDR_VRSN_CD1
ICD_PRCDR_VRSN_CD2
ICD_PRCDR_VRSN_CD3
ICD_PRCDR_VRSN_CD4
ICD_PRCDR_VRSN_CD5
ICD_PRCDR_VRSN_CD6
ICD_PRCDR_VRSN_CD7
ICD_PRCDR_VRSN_CD8
ICD_PRCDR_VRSN_CD9
ICD_PRCDR_VRSN_CD10
ICD_PRCDR_VRSN_CD11
ICD_PRCDR_VRSN_CD12
ICD_PRCDR_VRSN_CD13

ICD_PRCDR_VRSN_CD14
ICD_PRCDR_VRSN_CD15
ICD_PRCDR_VRSN_CD16
ICD_PRCDR_VRSN_CD17
ICD_PRCDR_VRSN_CD18
ICD_PRCDR_VRSN_CD19
ICD_PRCDR_VRSN_CD20
ICD_PRCDR_VRSN_CD21
ICD_PRCDR_VRSN_CD22
ICD_PRCDR_VRSN_CD23
ICD_PRCDR_VRSN_CD24
ICD_PRCDR_VRSN_CD25

LONG NAME:

ICD_PRCDR_VRSN_CD1
ICD_PRCDR_VRSN_CD2
ICD_PRCDR_VRSN_CD3
ICD_PRCDR_VRSN_CD4
ICD_PRCDR_VRSN_CD5
ICD_PRCDR_VRSN_CD6
ICD_PRCDR_VRSN_CD7
ICD_PRCDR_VRSN_CD8
ICD_PRCDR_VRSN_CD9
ICD_PRCDR_VRSN_CD10
ICD_PRCDR_VRSN_CD11
ICD_PRCDR_VRSN_CD12
ICD_PRCDR_VRSN_CD13
ICD_PRCDR_VRSN_CD14
ICD_PRCDR_VRSN_CD15
ICD_PRCDR_VRSN_CD16
ICD_PRCDR_VRSN_CD17
ICD_PRCDR_VRSN_CD18
ICD_PRCDR_VRSN_CD19
ICD_PRCDR_VRSN_CD20
ICD_PRCDR_VRSN_CD21
ICD_PRCDR_VRSN_CD22
ICD_PRCDR_VRSN_CD23
ICD_PRCDR_VRSN_CD24
ICD_PRCDR_VRSN_CD25

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

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IME_OP_CLM_VAL_AMT

LABEL: Operating Indirect Medical Education (IME) Amount

DESCRIPTION: This is one component of the total amount that is payable on PPS claims, and reflects the IME (indirect medical education) payments for operating expenses (such as labor) for the claim.

There are two types of IME amounts that may be payable for many PPS claims; the other type of IME payment is for the IME capital amount (variable called CLM_PPS_CPTL_IME_AMT). Both operating and capital IME payments are components of the PPS, as well as numerous other factors.

SHORT NAME: IME_OP

LONG NAME: IME_OP_CLM_VAL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics" (reference: https://www.medpac.gov/document-type/payment-basic/)

Also, in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html)

Derivation Rules: If there is a value code "19" (i.e., in the value code file, if the VAL_CD="19") then this dollar amount (VAL_AMT) is used to populate this field.

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LINE_1ST_EXPNS_DT

LABEL: Line First Expense Date

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

SHORT NAME: EXPNSDT1

LONG NAME: LINE_1ST_EXPNS_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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LINE_ADJUST_GRP_CD

LABEL: Line Adjustment Group Code

DESCRIPTION: Claim adjustment group code used to categorize a payment adjustment for a claim or claim line. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: LINE_ADJUST_GRP_CD

LONG NAME: LINE_ADJUST_GRP_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: CO = Contractual obligation
OA = Other adjustment
PR = Patient responsibility

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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LINE_ADJUST_RSN_CD

LABEL: Line Adjustment Reason Code

DESCRIPTION: Claim adjustment reason code used to describe why a claim or claim line was paid differently than billed. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: LINE_ADJUST_RSN_CD

LONG NAME: LINE_ADJUST_RSN_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: This is not a comprehensive list of values; refer to website below for current values and descriptions:
132 = Prearranged demonstration project adjustment

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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LINE_ALOWD_CHRG_AMT

LABEL: Line Allowed Charge Amount

DESCRIPTION: The amount of allowed charges for the line-item service on the non-institutional claim.

This charge is used to compute the total claim-level payment to providers or reimbursement to beneficiaries.

SHORT NAME: LALOWCHG

LONG NAME: LINE_ALOWD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: The amount includes both the line-item Medicare and beneficiary-paid amounts (i.e., deductible and coinsurance).

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LINE_BENE_PMT_AMT

LABEL: Line Payment Amount to Beneficiary

DESCRIPTION: The payment (reimbursement) made to the beneficiary related to the line-item service on the non-institutional claim.

SHORT NAME: LBENPMT

LONG NAME: LINE_BENE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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LINE_BENE_PRMRY_PYR_CD

LABEL: Line Primary Payer Code (if not Medicare)

DESCRIPTION: The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line-item service on the non-institutional claim.

The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.

SHORT NAME: LPRPAYCD

LONG NAME: LINE_BENE_PRMRY_PYR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH, VA, DOL, SSA

VALUES:
A = Working aged bene/spouse with employer group health plan (EGHP)
B = End-stage renal disease (ESRD) beneficiary in the 18-month coordination period with an employer group health plan
C = Conditional payment by Medicare; future reimbursement expected
D = Automobile no-fault
E = Workers' compensation
F = Public Health Service or other federal agency (other than Dept. of Veterans Affairs)
G = Working disabled bene (under age 65 with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
L = Any liability insurance
M = Override code: EGHP services involved
N = Override code: non-EGHP services involved
W = Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)
Null/missing= Medicare is primary payer

COMMENT: Values C, M, N, and null/missing indicate Medicare is primary payer.

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LINE_BENE_PRMRY_PYR_PD_AMT

LABEL: Line Primary Payer (if not Medicare) Paid Amount

DESCRIPTION: The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for the line-item service on the non-institutional claim.

SHORT NAME: LPRPDAMT

LONG NAME: LINE_BENE_PRMRY_PYR_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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LINE_BENE_PTB_DDCTBL_AMT

LABEL: Line Beneficiary Part B Deductible Amount

DESCRIPTION: The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line-item service on the non-institutional claim.

SHORT NAME: LDEDAMT

LONG NAME: LINE_BENE_PTB_DDCTBL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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LINE_CMS_TYPE_SRVC_CD

LABEL: Line CMS Type Service Code

DESCRIPTION: Code indicating the type of service, as defined in the CMS Medicare carrier Manual, for this line item on the non-institutional claim.

SHORT NAME: TYPSRVCB

LONG NAME: LINE_CMS_TYPE_SRVC_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

1 = Medical care
2 = Surgery
3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services
0 = Whole blood
A = Used durable medical equipment (DME)
D = Ambulance
E = Enteral/parenteral nutrients/supplies
F = Ambulatory surgical center (facility usage for surgical services)
G = Immunosuppressive drugs
J = Diabetic shoes
K = Hearing items and services
L = ESRD supplies
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies
T = Outpatient mental health limitation
U = Occupational therapy
V = Pneumococcal/flu vaccine
W = Physical therapy

COMMENT: —

^ Back to TOC ^

LINE_COINSRNC_AMT

LABEL: Line Beneficiary Coinsurance Amount

DESCRIPTION: The beneficiary coinsurance liability amount for this line-item service on the non-institutional claim.

This variable is the beneficiary's liability for coinsurance for the service on the line-item record.

Beneficiaries only face coinsurance once they have satisfied Part B's annual deductible, which applies to both institutional (e.g., Hospital outpatient) and non-institutional (e.g., carrier and DME) services.

For most Part B services, coinsurance equals 20 percent of the allowed amount.

SHORT NAME: COINAMT

LONG NAME: LINE_COINSRNC_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (reference the list of MLN publications at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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LINE_DME_PRCHS_PRICE_AMT

LABEL: Line DME Purchase Price Amount

DESCRIPTION: The amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the cap is met.

This line-item field is applicable to non-institutional claims involving DME, prosthetic, orthotic and supply items, immunosuppressive drugs, parenteral nutrition (PEN), ESRD and oxygen items referred to as DMEPOS.

SHORT NAME: DME_PURC

LONG NAME: LINE_DME_PRCHS_PRICE_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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LINE_DROP_OFF_ZIP_CD

LABEL: Line Drop Off Zip Code

DESCRIPTION: Line drop off zip code.

SHORT NAME: LINE_DROP_OFF_ZIP_CD

LONG NAME: LINE_DROP_OFF_ZIP_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: XXXXX

COMMENT: The drop off zip code is used for pricing ambulance services.

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LINE_HCT_HGB_RSLT_NUM

LABEL: Hematocrit/Hemoglobin Test Results

DESCRIPTION: This is the laboratory value for the most recent hematocrit or hemoglobin reading on the non-institutional claim.

SHORT NAME: HCTHGBRS

LONG NAME: LINE_HCT_HGB_RSLT_NUM

TYPE: NUM

LENGTH: 4

SOURCE: NCH

VALUES: —

COMMENT: This variable became effective 9/2008 to comply with CR# 5699.

There is a variable to indicate the type of test — whether hematocrit or hemoglobin (variable called LINE_HCT_HGB_TYPE_CD).

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LINE_HCT_HGB_TYPE_CD

LABEL: Hematocrit/Hemoglobin Test Type Code

DESCRIPTION: The type of test that was performed — hematocrit or hemoglobin.

SHORT NAME: HCTHGBTP

LONG NAME: LINE_HCT_HGB_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: R1 = Hemoglobin Test
R2 = Hematocrit Test

COMMENT: This variable became effective 9/2008 to comply with CR# 5699.

The laboratory value for the test is indicated in the hematocrit/hemoglobin test results field (variable called LINE_HCT_HGB_RSLT_NUM).

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LINE_ICD_DGNS_CD

LABEL: Line Diagnosis Code

DESCRIPTION: The code indicating the diagnosis supporting this line-item procedure/service on the non-institutional claim.

SHORT NAME: LINE_ICD_DGNS_CD

LONG NAME: LINE_ICD_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

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

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

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LINE_ICD_DGNS_VRSN_CD

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

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

SHORT NAME: LINE_ICD_DGNS_VRSN_CD

LONG NAME: LINE_ICD_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

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LINE_LAST_EXPNS_DT

LABEL: Line Last Expense Date

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

It is almost always the same as the line-level first expense date (variable called LINE_1ST_EXPNS_DT); exception is for DME claims — where some services are billed in advance.

SHORT NAME: EXPNSDT2

LONG NAME: LINE_LAST_EXPNS_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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LINE_NCH_PMT_AMT

LABEL: Line NCH Medicare Payment Amount

DESCRIPTION: Amount of payment made from the Medicare trust fund (after deductible and coinsurance amounts have been paid) for the line-item service on the non-institutional claim.

SHORT NAME: LINEPMT

LONG NAME: LINE_NCH_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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LINE_NDC_CD

LABEL: Line National Drug Code (NDC)

DESCRIPTION: On the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs. This line-item field was added as a placeholder on the carrier claim.

SHORT NAME: LNNDCCD

LONG NAME: LINE_NDC_CD

TYPE: CHAR

LENGTH: 11

SOURCE: NCH

VALUES: —

COMMENT: —

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LINE_NUM

LABEL: Claim Line Number

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

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

All revenue center records or claim lines on a given claim have the same CLM_ID.

SHORT NAME: LINE_NUM

LONG NAME: LINE_NUM

TYPE: NUM

LENGTH: 13

SOURCE: CCW

VALUES: —

COMMENT: —

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LINE_OTHR_APLD_AMT1

LINE_OTHR_APLD_AMT2

LINE_OTHR_APLD_AMT3

LINE_OTHR_APLD_AMT4

LINE_OTHR_APLD_AMT5

LINE_OTHR_APLD_AMT6

LINE_OTHR_APLD_AMT7

LABEL: Line Other Applied Amount

DESCRIPTION: The field used to identify amounts that were used to adjust the amount payable when processing the line item.

SHORT NAME:

LINE_OTHR_APLD_AMT1	LINE_OTHR_APLD_AMT5
LINE_OTHR_APLD_AMT2	LINE_OTHR_APLD_AMT6
LINE_OTHR_APLD_AMT3	LINE_OTHR_APLD_AMT7
LINE_OTHR_APLD_AMT4	

LONG NAME:

LINE_OTHR_APLD_AMT1	LINE_OTHR_APLD_AMT5
LINE_OTHR_APLD_AMT2	LINE_OTHR_APLD_AMT6
LINE_OTHR_APLD_AMT3	LINE_OTHR_APLD_AMT7
LINE_OTHR_APLD_AMT4	

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Reference the associated line other applied indicator code in the LINE_OTHR_APLD_IND_CD{#} field.

There are up to seven of these line applied amount fields (LINE_OTHR_APLD_AMT1–LINE_OTHR_APLD_AMT7).

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LINE_OTHR_APLD_IND_CD1

LINE_OTHR_APLD_IND_CD2

LINE_OTHR_APLD_IND_CD3

LINE_OTHR_APLD_IND_CD4

LINE_OTHR_APLD_IND_CD5

LINE_OTHR_APLD_IND_CD6

LINE_OTHR_APLD_IND_CD7

LABEL: Line Other Applied Indicator Code

DESCRIPTION: The code used to identify the reason the claim payment amount was adjusted during claims processing.

SHORT NAME:

LINE_OTHR_APLD_IND_CD1
LINE_OTHR_APLD_IND_CD2
LINE_OTHR_APLD_IND_CD3
LINE_OTHR_APLD_IND_CD4
LINE_OTHR_APLD_IND_CD5
LINE_OTHR_APLD_IND_CD6
LINE_OTHR_APLD_IND_CD7

LONG NAME:

LINE_OTHR_APLD_IND_CD1
LINE_OTHR_APLD_IND_CD2
LINE_OTHR_APLD_IND_CD3
LINE_OTHR_APLD_IND_CD4
LINE_OTHR_APLD_IND_CD5
LINE_OTHR_APLD_IND_CD6
LINE_OTHR_APLD_IND_CD7

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

A = Gramm-Rudman reduction required for services (03/2003/1986–09/30/1986)
B = Interest addition
C = Positive rounding adjustment (due to line-item distribution from total claim reimbursement amount)
D = Negative rounding adjustment (due to line-item distribution from total claim reimbursement amount)
E = Primary Payer allowed charge
F = Payment Reduction (Good cause or Late Billing)
G = Payment Reduction (PMDP Demonstration Reduction)
H = Payment Reduction (Sequestration Reduction)
I = Payment Reduction (ePrescribing Negative Adjustment)
J = ACO Payment Adjustment Amount (Pioneer reduction) — the amount that would have been paid if not for the Pioneer reduction — eff. 1/2014
K = Payment Reduction (ASC Quality Reporting Payment Reduction) — eff. 1/2014

L = ACO Payment Adjustment Amount (Pioneer reduction) — the actual amount of the Pioneer reduction — eff. 1/2014
M = Payment Reduction (Physician Quality Reporting System [PQRS] Negative Payment Adjustment) — eff. 1/2015
N = None (no amount to apply)
O = Negative or Positive Adjustment (Value Based Modifier [VBM] for reduction) — eff. 1/2015
P = Value Based Payment Modifier (VBM) Positive Payment Adjustment — eff. 1/2015
Q = Electronic Health Record (EHR) Negative Payment Adjustment — eff. 1/2015
R = Appropriate/Allowable Co-insurance (4/2023) previous value - Part B Drug Payment Model (retired)
S = Prior Authorization Reduction — eff. 10/2016
T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment — eff. 4/2017
U = Maryland Primary Care Program (MDPCP) Adjustment — eff. 1/2019
V = Positive Amount for Quality Payment Program (QPP) payment adjustment — eff. 1/2019
W = Negative Amount for Quality Payment Program (QPP) payment adjustment — eff. 1/2019
X = Emergency Triage, Treat, and Transport (ET3) Model Payment — to indicate the amount by which each line was adjusted for the 15% bonus payment. — eff. 1/2020
Y = Oncology Care Model Plus (OCM+) Population Based Payment Claims Reductions — eff. 1/2020
A2 = Flat Visit Reduction Amount (PCF Model)
A3 = Flat Visit Fee Increased Amount (PCF Model)
A4 = KCF Model Reduction Amount
A5 = CKCC Model Reduction Amount
A6 = Performance Payment Adjustment (PPA) Addition (eff. 1/2022)
A7 = Performance Payment Adjustment (PPA) Reduction (eff. 1/2022)
A8 = Performance Based Adjustment (PBA) Addition (eff. 4/2022)
A9 = Performance Based Adjustment (PBA) Reduction (eff. 4/2022)
B1 = PTA/OTA 15% reduction for Therapy (eff.1/2022)
B2 = Co-Insurance Reduction Amount (eff. 1/2023)
B3 = Monthly Enhanced Oncology Services (MEOS) Positive Payment Adjustment (eff. 4/2023)
B4 = Making Care Primary (MCP) reduction amount
B5 = Performance Based Adjustment (PBA) Positive Amount
B6 = Performance Based Adjustment (PBA) Negative Amount
B7 = Health Equity Adjustment (HEA) Positive Amount
B8 = Health Equity Adjustment (HEA) Negative Amount

COMMENT: Starting in January 2021 with NCH version L, this field was changed from 1 character to 2.

Reference the associated amounts in the LINE_OTHR_APLD_AMT{#} field.

There are up to 7 of these line applied indicator fields (LINE_OTHR_APLD_IND_CD1–LINE_OTHR_APLD_IND_CD7).

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LINE_PICK_UP_ZIP_CD

LABEL: Line Point of Pickup Zip Code

DESCRIPTION: Line Point of Pickup Zip Code.

SHORT NAME: LINE_POINT_OF_PCKP_ZIP_CD

LONG NAME: LINE_POINT_OF_PCKP_ZIP_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: XXXXX

COMMENT: The point of pickup zip code is used for pricing ambulance services.

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LINE_PLACE_OF_SRVC_CD

LABEL: Line Place of Service Code

DESCRIPTION: The code indicating the place of service, as defined in the Medicare carrier manual, for this line item on the non-institutional claim.

SHORT NAME: PLCSRVC

LONG NAME: LINE_PLACE_OF_SRVC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
01 = Pharmacy — facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients
02 = Telehealth provided other than in patient's home (eff. 1/2017)
03 = School — 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 — 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 — 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 = Telehealth provided in patient's home
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, seven days a week, with the capacity to deliver or arrange for services including some health care and other services
14 = Group home — 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 — facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services
16 = Temporary lodging (eff. 4/2008)
17 = Walk-in retail health clinic. (No later than 5/2010)
18 = Place of employment — worksite. A location, not described by any other POS code, owned, or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual. (This code is available for use eff. January 1, 2013, but no later than May 1, 2013)
19 = Off campus — outpatient hospital. (eff. 1/2016)
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 — 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 = On-campus outpatient hospital — 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 — freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis
25 = Birthing center — 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 newborn infants
26 = Military treatment facility — 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 = Outreach site/Street (eff. 10/2023)
28 = Unassigned. N/A
29 = Unassigned. N/A
30 = Unassigned. N/A
31 = Skilled nursing facility — 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 — 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 — 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 — 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. (eff. 10/2003)
50 = Federal Qualified Health Center — 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 — 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 center — 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/Individuals with intellectual disabilities — facility which primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF
55 = Residential substance abuse treatment facility — 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 — 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 — 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 = Non-residential opioid treatment facility (eff. 1/2020)
59 = Unassigned. N/A
60 = Mass immunization center — 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 — 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 — 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 — 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 = Programs of All Inclusive Care for the Elderly (PACE) Center

67–70 = Unassigned. N/A

71 = Public health clinic — 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 — 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 — laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office

82–98 = Unassigned. N/A

99 = Other place of service — other place of service not identified above

COMMENT: —

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LINE_PMT_80_100_CD

LABEL: Line Payment 80%/100% Code

DESCRIPTION: The code indicating that the amount shown in the payment field on the non-institutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.

SHORT NAME: PMTINDSW

LONG NAME: LINE_PMT_80_100_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = 80%
1 = 100%
3 = 100% Limitation of liability only
4 = 75% Reimbursement

COMMENT: —

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LINE_PRCSG_IND_CD

LABEL: Line Processing Indicator Code

DESCRIPTION: The code on a non-institutional claim indicating to whom payment was made or if the claim was denied.

SHORT NAME: PRCNGIND

LONG NAME: LINE_PRCSG_IND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
A = Allowed
B = Benefits exhausted
C = Non-covered care
D = Denied (from BMAD)
G = MSP cost avoided — secondary claims investigation
H = MSP cost avoided — self reports
I = Invalid data
J = MSP cost avoided — 411.25
K = MSP cost avoided — insurer voluntary reporting
L = CLIA
M = Multiple submittal-duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial
Q = MSP cost avoided (contractor #88888) — voluntary agreement
R = Reprocessed adjustments based on subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided — IEQ contractor
U = MSP cost avoided — HMO rate cell adjustment
V = MSP cost avoided — litigation settlement
X = MSP cost avoided — generic
Y = MSP cost avoided — IRS/SSA data match project
Z = Bundled test, no payment
00 = MSP cost avoided — COB contractor
12 = MSP cost avoided — BC/BS voluntary agreements
13 = MSP cost avoided — Office of Personnel Management
14 = MSP cost avoided — Workman's Compensation (WC) Datamatch
15 = MSP cost avoided — Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)
16 = MSP cost avoided — Liability Insurer VDSA (eff.4/2006)
17 = MSP cost avoided — No-Fault Insurer VDSA (eff.4/2006)
18 = MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (eff.4/2006)
21 = MSP cost avoided — MIR Group Health Plan (eff.1/2009)

22 = MSP cost avoided — MIR non-Group Health Plan (eff.1/2009)
25 = MSP cost avoided — Recovery Audit Contractor — California (eff.10/2005)
26 = MSP cost avoided — Recovery Audit Contractor — Florida (eff.10/2005)

Effective 4/1/2002, the Line Processing Indicator code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code.

Below are the character codes (found in NCH and NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

! MSP cost avoided — COB Contractor (“00” 2-byte code)

@ MSP cost avoided — BC/BS Voluntary Agreements (“12” 2-byte code)

MSP cost avoided — Office of Personnel Management (“13” 2-byte code)

$ MSP cost avoided — Workman’s Compensation (WC) Datamatch (“14” 2-byte code)

* MSP cost avoided — Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (“15” 2-byte code) (eff. 4/2006)

(MSP cost avoided — Liability Insurer VDSA (“16” 2-byte code) (eff. 4/2006)

) MSP cost avoided — No-Fault Insurer VDSA (“17” 2-byte code) (eff. 4/2006)

+ MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (“18” 2-byte code) (eff. 4/2006)

< MSP cost avoided — MIR Group Health Plan (“21” 2-byte code) (eff. 1/2009)

> MSP cost avoided — MIR non-Group Health Plan (“22” 2-byte code) (eff. 1/2009)

% MSP cost avoided — Recovery Audit Contractor — California (“25” 2-byte code) (eff. 10/2005)

& MSP cost avoided — Recovery Audit Contractor — Florida (“26” 2-byte code) (eff. 10/2005)

COMMENT: —

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LINE_PRMRY_ALOWD_CHRG_AMT

LABEL: Line Primary Payer Allowed Charge Amount

DESCRIPTION: The primary payer allowed charge amount for the line-item service on the non-institutional claim.

If there is a primary payer other than Medicare, there may be an allowed payment for the provider; if so, this field is populated.

SHORT NAME: PRPYALOW

LONG NAME: LINE_PRMRY_ALOWD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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LINE_PRVDR_PMT_AMT

LABEL: Line Provider Payment Amount

DESCRIPTION: The payment made by Medicare to the provider for the line-item service on the non-institutional claim. Additional payments may have been made to the provider — including beneficiary deductible and coinsurance amounts and/or other primary payer amounts.

SHORT NAME: LPRVPMT

LONG NAME: LINE_PRVDR_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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LINE_PRVDR_VLDTN_TYPE_CD

LABEL: Line Provider Validation Type Code

DESCRIPTION: Line provider validation type code for carrier claim lines

SHORT NAME: LINE_PRVDR_VLDTN_TYPE_CD

LONG NAME: LINE_PRVDR_VLDTN_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: RP = Rendering Provider
OP = Operating Physician
CP = Ordering/ Referring Physician
AP = Attending Physician
FA = Facility

COMMENT: The purpose of the Provider Validation Type field on the claim is to inform Common Working File (CWF) to perform an edit check to ensure that the provider that was submitted on the prior authorization (PA) request is the same provider on the claim.

This field was new in April 2019.

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LINE_RA_RMRK_CD

LABEL: Line Remittance Advice Remark Code

DESCRIPTION: Claim remittance advice remark code used to provide an additional explanation for an adjustment already described by a claim adjustment reason code (CARC) for a claim or claim line. It is also used to communicate information about remittance processing. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: LINE_RA_RMRK_CD

LONG NAME: LINE_RA_RMRK_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: This is not a comprehensive list of values; refer to website below for current values and descriptions: N83 = No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

^ Back to TOC ^

LINE_RP_IND_CD

LABEL: Line Representative Payee (RP) Indicator Code

DESCRIPTION: Line Representative Payee (RP) Indicator Code

SHORT NAME: LINE_RP_IND_CD

LONG NAME: LINE_RP_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: R = bypass representative payee

COMMENT: This field is used to designate by-passing of the prior authorization processing for claims with a representative payee when an "R" is present in the field.

Data will not start coming in until April 2016.

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LINE_RR_BRD_EXCLSN_IND_SW

LABEL: Line Railroad Board Exclusion Indicator Switch

DESCRIPTION: This field indicates whether Railroad Board (RRB) beneficiary durable medical equipment (DME) claim line should be excluded from Prior Authorization (PA) processing.

SHORT NAME: LINE_RR_BRD_EXCLSN_IND_SW

LONG NAME: LINE_RR_BRD_EXCLSN_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes (exclude RRB beneficiary from PA)
Null/missing = Subject RRB beneficiary services to prior authorization

COMMENT: This field informs the SSMs and CWF if the RRB beneficiary claim should either be included or excluded from Prior Authorization (PA) processing. (e.g., if the field is valued “Y”, and it is RRB beneficiary claim, it will be excluded from PA processing).

This field was new in April 2019.

^ Back to TOC ^

LINE_RSDL_PYMT_IND_CD

LABEL: Line Residual Payment Indicator Code

DESCRIPTION: This field is used by CWF claims processing for the purpose of bypassing its normal MSP editing that would otherwise apply for ongoing responsibility for medicals (ORM) or worker's compensation Medicare Set-Aside Arrangements (WCMSA). Normally, CWF does not allow a secondary payment on MSP involving ORM or WCMSA, so the residual payment indicator is used to allow CWF to make an exception to its normal routine.

SHORT NAME: LINE_RSDL_PYMT_IND_CD

LONG NAME: LINE_RSDL_PYMT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: X = Residual Payment

COMMENT: This field was new in April 2016 and is null/missing for all previous years.

^ Back to TOC ^

LINE_SBMTD_CHRG_AMT

LABEL: Line Submitted Charge Amount

DESCRIPTION: The amount of submitted charges for the line-item service on the non-institutional claim.

Providers' submitted charges often differ from the amount they were eventually paid — either from Medicare, the beneficiary (through deductible or coinsurance amounts) or third-party payers.

SHORT NAME: LSBMTCHG

LONG NAME: LINE_SBMTD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

^ Back to TOC ^

LINE_SERVICE_DEDUCTIBLE

LABEL: Line Service Deductible Indicator Switch

DESCRIPTION: Switch indicating whether or not the line-item service on the non-institutional claim is subject to a deductible.

SHORT NAME: DED_SW

LONG NAME: LINE_SERVICE_DEDUCTIBLE

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = Service Subject to Deductible
1 = Service Not Subject to Deductible

COMMENT: —

^ 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.

SHORT NAME: SRVC_CNT

LONG NAME: LINE_SRVC_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field may have decimals (it is formatted as SAS length 11.3).

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LINE_VLNTRY_SRVC_IND_CD

LABEL: Line Voluntary Service Indicator Code

DESCRIPTION: Effective with version "L" of the NCH layout, this line level field will be used to identify if the service (procedure code) was voluntary or required.

SHORT NAME: LINE_VLNTRY_SRVC_IND_CD

LONG NAME: LINE_VLNTRY_SRVC_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: V = A voluntary procedure code
Null/missing = A required procedure code

COMMENT: This field was new in January 2021.

^ Back to TOC ^

LTCH_DSCHRG_PYMT_ADJSTMT_AMT

LABEL: LTCH Discharge Payment Adjustment Amount

DESCRIPTION: Identifies the amount of a long-term care hospital discharge payment percentage adjustment that will be applied to the payment rate for failure to maintain the required discharge payment percentage.

SHORT NAME: LTCH_DSCHRG_PYMT_ADJSTMT_AMT

LONG NAME: LTCH_DSCHRG_PYMT_ADJSTMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: The adjustment has been applied to the Claim Payment Amount (CLM_PMT_AMT).

This field is new with the NCH version L layout; it is not populated before January 2021.

^ Back to TOC ^

MS_DRG_GRPR_VRSN_CD

LABEL: MS-DRG Grouper Version Code

DESCRIPTION: This field displays the Medicare-Severity Diagnosis Related Group (MS-DRG) Grouper version for the inpatient or skilled nursing facility (SNF) claim.

SHORT NAME: MS_DRG_GRPR_VRSN_CD

LONG NAME: MS_DRG_GRPR_VRSN_CD

TYPE: CHAR

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated prior to 2021. GROUPER is the software that determines the DRG from data elements reported by the hospital.

Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment.

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

^ Back to TOC ^

NCH_ACTV_OR_CVRD_LVL_CARE_THRU

LABEL: NCH Active or Covered Level Care Thru Date

DESCRIPTION: The date on a claim for which the covered level of care ended in a general hospital or the active care ended in a psychiatric/tuberculosis hospital.

SHORT NAME: CARETHRU

LONG NAME: NCH_ACTV_OR_CVRD_LVL_CARE_THRU

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: This variable is derived, using the occurrence code (variable called CLM_RLT_OCRNC_CD), when the value is 22. When this code value is present the date is populated using the CLM_RLT_OCRNC_DT.

^ Back to TOC ^

NCH_BENE_BLOOD_DDCTBL_LBLTY_AM

LABEL: NCH Beneficiary Blood Deductible Liability Amount

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

A blood deductible amount applies to the first three pints of blood (or equivalent units; applies only to whole blood or packed red cells — not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

SHORT NAME: BLDDEDAM

LONG NAME: NCH_BENE_BLOOD_DDCTBL_LBLTY_AM

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA PROCESS

VALUES: XXX.XX

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

^ Back to TOC ^

NCH_BENE_DSCHRG_DT

LABEL: NCH Beneficiary Discharge Date

DESCRIPTION: On an inpatient or home health claim, the date the beneficiary was discharged from the facility, or died.

Date matches the "thru" date on the claim (CLM_THRU_DT) unless the beneficiary is still a patient (i.e., this field is not populated if discharge status code [PTNT_DSCHRG_STUS_CD]= 30 [still a patient]). When there is a discharge date, the PTNT_DSCHRG_STUS_CD indicates the final disposition of the patient after discharge.

SHORT NAME: DSCHRGDT

LONG NAME: NCH_BENE_DSCHRG_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: —

^ Back to TOC ^

NCH_BENE_IP_DDCTBL_AMT

LABEL: NCH Beneficiary Inpatient (or other Part A) Deductible Amount

DESCRIPTION: The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.

Under Part A, the deductible applies only to inpatient hospital care (whether in an acute care facility, inpatient psychiatric facility [IPF], inpatient rehabilitation facility [IRF], or long-term care hospital [LTCH]) and is charged only at the beginning of each benefit period, which is similar to an episode of illness.

This variable is null/missing for skilled nursing facility (SNF), home health, and hospice claims.

SHORT NAME: DED_AMT

LONG NAME: NCH_BENE_IP_DDCTBL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Costs to beneficiaries are described in detail on the Medicare.gov website.

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NCH_BENE_MDCR_BNFTS_EXHTD_DT_I

LABEL: NCH Beneficiary Medicare Benefits Exhausted Date

DESCRIPTION: The last date for which the beneficiary has Medicare coverage.

This is completed only where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim.

SHORT NAME: EXHST_DT

LONG NAME: NCH_BENE_MDCR_BNFTS_EXHTD_DT_I

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA process

VALUES: —

COMMENT: Derived from: CLM_RLT_OCRNC_CD and CLM_RLT_OCRNC_DT

Derivation rules: Based on the presence of occurrence code A3, B3, or C3 move the related occurrence date to NCH_MDCR_BNFT_EXHST_DT.

^ Back to TOC ^

NCH_BENE_PTA_COINSRNC_LBLTY_AM

LABEL: NCH Beneficiary Part A Coinsurance Liability Amount

DESCRIPTION: The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim.

Under Part A, beneficiaries pay coinsurance starting with the 61st day of an inpatient hospital stay (one daily amount for days 61–90, and a higher daily amount for any days after that, which count towards a beneficiary's 60 lifetime reserve days) or the 21st day of a skilled nursing facility (SNF) stay (a daily amount for days 21–100, after which SNF coverage ends).

This variable is null/missing for home health and hospice claims.

SHORT NAME: COIN_AMT

LONG NAME: NCH_BENE_PTA_COINSRNC_LBLTY_AM

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Costs to beneficiaries are described in detail on the Medicare.gov website.

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NCH_BENE_PTB_COINSRNC_AMT

LABEL: NCH Beneficiary Part B Coinsurance Amount

DESCRIPTION: The amount of money for which the intermediary has determined that the beneficiary is liable for Part B coinsurance on the institutional claim.

SHORT NAME: PTB_COIN

LONG NAME: NCH_BENE_PTB_COINSRNC_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA PROCESS

VALUES: XXX.XX

COMMENT: Derivation Rules: If value codes (variable called CLM_VAL_CD) = A2, B2, or C2, then the related value amount (variable called CLM_VAL_AMT) is output to this field.

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NCH_BENE_PTB_DDCTBL_AMT

LABEL: NCH Beneficiary Part B Deductible Amount

DESCRIPTION: The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B cash deductible on the claim.

SHORT NAME: PTB_DED

LONG NAME: NCH_BENE_PTB_DDCTBL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA PROCESS

VALUES: XXX.XX

COMMENT: Derivation Rules: If value codes (variable called CLM_VAL_CD) = A1, B1, or C1, then the related value amount (variable called CLM_VAL_AMT) is output to this field.

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NCH_BLOOD_PNTS_FRNSHD_QTY

LABEL: NCH Blood Pints Furnished Quantity

DESCRIPTION: Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).

SHORT NAME: BLDFRNSH

LONG NAME: NCH_BLOOD_PNTS_FRNSHD_QTY

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: —

COMMENT: —

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NCH_CARR_CLM_ALOWD_AMT

LABEL: NCH Carrier Claim Allowed Charge Amount (sum of all line-level allowed charges)

DESCRIPTION: The total allowed charges on the claim (the sum of line item allowed charges).

SHORT NAME: ALOWCHRG

LONG NAME: NCH_CARR_CLM_ALOWD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: Sum of all the line LINE_NCH_PMT_AMT values for the claim.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

^ Back to TOC ^

NCH_CARR_CLM_SBMTD_CHRG_AMT

LABEL: NCH Carrier Claim Submitted Charge Amount (sum of all line-level submitted charges)

DESCRIPTION: The total submitted charges on the claim (sum of all line-level submitted charges, variable called LINE_SBMTD_CHRG_AMT).

SHORT NAME: SBMTCHRG

LONG NAME: NCH_CARR_CLM_SBMTD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: The charges the provider submits may be different than the amount that Medicare or a secondary payer will allow for the claim — and this amount is also different than the actual Medicare or beneficiary paid amounts.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also, in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

^ Back to TOC ^

NCH_CLM_BENE_PMT_AMT

LABEL: NCH Claim Payment Amount to Beneficiary

DESCRIPTION: The total payments made to the beneficiary for this claim (sum of all line-level payments to beneficiary, variable called LINE_BENE_PMT_AMT).

SHORT NAME: BENE_PMT

LONG NAME: NCH_CLM_BENE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: This variable is populated if, for example, a beneficiary pays for a service that should have been Medicare-covered.

The beneficiary can be refunded the payment.

Costs to that beneficiaries are liable for are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits," which explains the deductibles and coinsurance amounts.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also, in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference the list of MLN publications at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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NCH_CLM_PRVDR_PMT_AMT

LABEL: NCH Claim Provider Payment Amount

DESCRIPTION: The total payments made to the provider for this claim (sum of line-item provider payment amounts (variable called LINE_PRVDR_PMT_AMT).

SHORT NAME: PROV_PMT

LONG NAME: NCH_CLM_PRVDR_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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NCH_CLM_TYPE_CD

LABEL: NCH Claim Type Code

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

SHORT NAME: CLM_TYPE

LONG NAME: NCH_CLM_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
10 = Home health agency (HHA) claim
20 = Non swing bed skilled nursing facility (SNF) claim
30 = Swing bed SNF claim
40 = Hospital outpatient claim
50 = Hospice claim
60 = Inpatient claim
71 = Local carrier non-durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claim
72 = Local carrier DMEPOS claim
81 = Durable medical equipment regional carrier (DMERC); non-DMEPOS claim
82 = DMERC; DMEPOS claim

COMMENT: This variable may not always indicate the type of service performed; for example, when the claim type code = 60 (inpatient), the services may actually be for post-acute care. Additional information regarding the type of service on the claim can be found in a CCW Technical Guidance document entitled: "Getting Started with Medicare data".

Note that there is a data issue with the incorrect assignment of National Claims History (NCH) claim type codes for 37,962 Part B carrier and DMERC (claim type codes 71,72,81,82) claims processed on 01/27/23 (i.e., the NCH_WKLY_PROC_DT). For nearly all of the affected claims, the NCH_CLM_TYPE_CD was incorrectly assigned an 81 instead of 82; there are also 7 of the total impacted claims where the NCH_CLM_TPYE_CD was incorrectly assigned 71 instead of 72.

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NCH_DRG_OUTLIER_APRVD_PMT_AMT

LABEL: NCH DRG Outlier Approved Payment Amount

DESCRIPTION: On an institutional claim, the additional payment amount approved by the Quality Improvement Organization due to an outlier situation for a beneficiary's stay under the prospective payment system (PPS), which has been classified into a specific diagnosis related group (DRG).

This variable will typically include the total outlier payment amount, if any, for the claim.

SHORT NAME: OUTLRPMT

LONG NAME: NCH_DRG_OUTLIER_APRVD_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: —

COMMENT: —

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NCH_IP_NCVRD_CHRG_AMT

LABEL: NCH Inpatient (or other Part A) Non-covered Charge Amount

DESCRIPTION: The non-covered charges for all accommodations and services, reported on an inpatient claim (used for internal NCHMQA editing purposes).

SHORT NAME: NCCHGAMT

LONG NAME: NCH_IP_NCVRD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: DERIVED FROM:

- REV_CNTR_CD
- REV_CNTR_NCVR_CHRG_AMT

Derivation Rules: Based on the presence of revenue center code equal to 0001, move the related non-covered charge amount to NCH_IP_NCOV_CHRG_AMT.

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NCH_IP_TOT_DDCTN_AMT

LABEL: NCH Inpatient (or other Part A) Total Deductible/Coinsurance Amount

DESCRIPTION: The total of all Part A and blood deductibles and coinsurance amounts on the claim.

SHORT NAME: TDEDAMT

LONG NAME: NCH_IP_TOT_DDCTN_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: Derivation Rules: Accumulate the value amounts (from field called CLM_VAL_AMT) associated with value codes (CLM_VAL_CD) equal to 06, 08 thru 11 and A1, B1, or C1 and output to this field.

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NCH_NEAR_LINE_REC_IDENT_CD

LABEL: NCH Near Line Record Identification Code (RIC)

DESCRIPTION: A code defining the type of claim record being processed.

SHORT NAME: RIC_CD

LONG NAME: NCH_NEAR_LINE_REC_IDENT_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: M = Part B DMEPOS claim record (processed by DME regional carrier)
O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
U = Both Part A and B institutional home health agency (HHA) claim records
V = Part A institutional claim record (inpatient [IP], skilled nursing facility [SNF], hospice [HOS], or home health agency [HHA])
W = Part B institutional claim record (outpatient [HOP], HHA)

COMMENT: —

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NCH_PRMRY_PYR_CLM_PD_AMT

LABEL: NCH Primary Payer (if not Medicare) Claim Paid Amount

DESCRIPTION: The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.

SHORT NAME: PRPAYAMT

LONG NAME: NCH_PRMRY_PYR_CLM_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Derivation Rules: It is calculated as the sum of the line-level primary payer amounts.

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NCH_PRMRY_PYR_CD

LABEL: NCH Primary Payer Code (if not Medicare)

DESCRIPTION: The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills.

The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.

SHORT NAME: PRPAY_CD

LONG NAME: NCH_PRMRY_PYR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
A = Employer group health plan (EGHP) insurance for an aged beneficiary
B = EGHP insurance for an end-stage renal disease (ESRD) beneficiary
C = Conditional payment by Medicare; future reimbursement from the Public Health Service (PHS) expected
D = No fault automobile insurance
E = Worker's compensation (WC)
F = Public Health Service (PHS) or other federal agency (other than VA)
G = Working disabled beneficiary under age 65 with a local government health plan (LGHP)
H = Black lung (BL) program
I = Department of Veteran's Affairs
L = Any liability insurance
M = Override EGHP — Medicare is primary payer
N = Override non-EGHP — Medicare is primary payer
Blank /missing = No other primary payer

COMMENT: —

^ Back to TOC ^

NCH_PROFNL_CMPNT_CHRG_AMT

LABEL: Professional Component Charge Amount

DESCRIPTION: This field is the amount of physician and other professional charges covered under Medicare Part B.

SHORT NAME: PCCHGAMT

LONG NAME: NCH_PROFNL_CMPNT_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: This variable is not populated for home health or hospice claims.

This field is used for CMS editing purposes and other internal processes (e.g., if computing interim payments, then these charges are deducted).

The source of information for this field for institutional claims is the CLM_VAL_AMT (when the code = 04 or 05, it indicates a professional component charge amount).

For outpatient claims, this information is from the revenue center codes (when the code=096*, 097* or 098*, then the REV_CNTR_TOT_CHRG_AMT indicates a professional component charge amount).

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NCH_PTNT_STUS_IND_CD

LABEL: NCH Patient Status Indicator Code

DESCRIPTION: This variable is a recoded version of the discharge status code (variable called PTNT_DSCHRG_STUS_CD).

SHORT NAME: PTNTSTUS

LONG NAME: NCH_PTNT_STUS_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH QA Process

VALUES: A = Discharged
B = Died
C = Still a patient

COMMENT: This field should not be used prior to March 2024 due to inaccuracies in the derivation of this field. Use the PTNT_DSCHRG_STUS_CD instead.

^ Back to TOC ^

NCH_QLFYD_STAY_FROM_DT

LABEL: NCH Qualified Stay From Date

DESCRIPTION: The beginning date of the beneficiary's qualifying Medicare stay.

For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization of benefits.

For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an “A” (transfer from critical access hospital), or at least three days in a row if the source of admission is other than “A”.

SHORT NAME: QLFYFROM

LONG NAME: NCH_QLFYD_STAY_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_OCRNC_SPAN_CD) 70. When this code value is present the date is populated using the CLM_OCRNC_SPAN_FROM_DT.

^ Back to TOC ^

NCH_QLFYD_STAY_THRU_DT

LABEL: NCH Qualified Stay Through Date

DESCRIPTION: The ending date of the beneficiary's qualifying Medicare stay.

For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization of benefits.

For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an “A” (transfer from critical access hospital), or at least three days in a row if the source of admission is other than “A”.

SHORT NAME: QLFYTHRU

LONG NAME: NCH_QLFYD_STAY_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_OCRNC_SPAN_CD) 70. When this code value is present the date is populated using the CLM_OCRNC_SPAN_THRU_DT.

^ Back to TOC ^

NCH_VRFD_NCVRD_STAY_FROM_DT

LABEL: NCH Verified Non-covered Stay From Date

DESCRIPTION: The beginning date of the beneficiary's Non-covered stay.

Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive.

For some beneficiaries, all days in one of these settings may not be covered by Medicare.

SHORT NAME: NCOVFROM

LONG NAME: NCH_VRFD_NCVRD_STAY_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM_SPAN_FROM_DT.

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NCH_VRFD_NCVRD_STAY_THRU_DT

LABEL: NCH Verified Non-covered Stay Through Date

DESCRIPTION: The ending date of the beneficiary's non-covered stay.

Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive.

For some beneficiaries, all days in one of these settings may not be covered by Medicare.

SHORT NAME: NCOVTHRU

LONG NAME: NCH_VRFD_NCVRD_STAY_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM_SPAN_THRU_DT.

^ Back to TOC ^

NCH_WKLY_PROC_DT

LABEL: NCH Weekly Claim Processing Date

DESCRIPTION: The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

SHORT NAME: WKLY_DT

LONG NAME: NCH_WKLY_PROC_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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OP_PHYSN_NPI

LABEL: Claim Operating Physician NPI Number

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

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

SHORT NAME: OP_NPI

LONG NAME: OP_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/2007 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no new UPINs (legacy numbers) will be generated for new physicians (Part B and outpatient claims), so there will only be NPIs sent into the NCH for those physicians.

^ Back to TOC ^

OP_PHYSN_SPCLTY_CD

LABEL: Claim Operating Physician Specialty Code

DESCRIPTION: The code used to identify the CMS specialty code corresponding to the operating physician. The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physicians is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.

SHORT NAME: OP_PHYSN_SPCLTY_CD

LONG NAME: OP_PHYSN_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative medicine
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathologist in private practice
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistant (eff. 4/2003 — previously grouped with Certified Registered Nurse Anesthetists (CRNA))
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology

47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotic personnel certified by an accrediting organization
56 = Individual certified prosthetic personnel certified by an accrediting organization
57 = Individual certified prosthetic-orthotic personnel certified by an accrediting organization
58 = Medical supply company with registered pharmacist
59 = Ambulance service (private)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist in private practice
66 = Rheumatology
67 = Occupational therapist in private practice
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or Multispecialty clinic or group practice (PA Group)
71 = Registered Dietician/Nutrition Professional (eff. 1/2002)
72 = Pain Management (eff. 1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug stores)
88 = Unknown provider
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/2001/2006). Prior to 07/2001/2006, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecological/oncology
99 = Unknown physician specialty

A0 = Hospital (DMERCs only)
A1 = Skilled nursing facility (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/2007)
B2 = Pedorthic Personnel (eff. 10/2/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and hyperbaric medicine
D5 = Opioid treatment program (eff. 1/2020)
D7 = Micrographic dermatologic surgery (MDS) (eff. 10/2020)
D8 = Adult congenital heart disease
E1 = Marriage and family therapists
E2 = Mental health counselors
E3 = Dental anesthesiology
E4 = Dental public health
E5 = Endodontics
E6 = Oral and maxillofacial pathology
E7 = Oral and maxillofacial radiology
E9 = Oral medicine
F1 = Orofacial pain
F2 = Orthodontics and dentofacial orthopedics
F3 = Pediatric dentistry
F4 = Periodontics
F5 = Prosthodontics

COMMENT: —

^ Back to TOC ^

OP_PHYSN_UPIN

LABEL: Claim Operating Physician UPIN Number

DESCRIPTION: On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.

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

SHORT NAME: OP_UPIN

LONG NAME: OP_PHYSN_UPIN

TYPE: CHAR

LENGTH: 6

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

ORDRG_PHYSN_NPI

LABEL: Revenue Center Ordering Physician NPI

DESCRIPTION: Effective with version “L” of the NCH layout, this line level field identifies the ordering physician’s National Provider Identifier (NPI).

SHORT NAME: ORDRG_PHYSN_NPI

LONG NAME: ORDRG_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: This field was new in January 2021.

^ Back to TOC ^

ORG_NPI_NUM

LABEL: Organization (or group) NPI Number

DESCRIPTION: The National Provider Identifier (NPI) of the organization or group practice.

SHORT NAME: ORGNPINM

LONG NAME: ORG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: On an institutional claim, this is the NPI number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

On the carrier claim, this is line-level information regarding the performing physician (Short Name = PRGRPNPI); it is the NPI of the group practice, where the performing physician is part of that group.

^ Back to TOC ^

OT_PHYSN_NPI

LABEL: Claim Other Physician NPI Number

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

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

SHORT NAME: OT_NPI

LONG NAME: OT_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/2007 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no new UPINs (legacy numbers) will be generated for new physicians (Part B and outpatient claims), so there will only be NPIs sent into the NCH for those physicians.

^ Back to TOC ^

OT_PHYSN_SPCLTY_CD

LABEL: Claim Other Physician Specialty Code

DESCRIPTION: The code used to identify the CMS specialty code corresponding to the other physician.

SHORT NAME: OT_PHYSN_SPCLTY_CD

LONG NAME: OT_PHYSN_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional pain management (IPM) (eff. 4/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative medicine
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathologist in private practice
16 = Obstetrics/gynecology
17 = Hospice and palliative care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistant (eff. 4/2003 — previously grouped with Certified Registered Nurse Anesthetists (CRNA))
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
47 = Independent diagnostic testing facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner

51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotic personnel certified by an accrediting organization
56 = Individual certified prosthetic personnel certified by an accrediting organization
57 = Individual certified prosthetic-orthotic personnel certified by an accrediting organization
58 = Medical supply company with registered pharmacist
59 = Ambulance service (private)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist in private practice
66 = Rheumatology
67 = Occupational therapist in private practice
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or Multispecialty clinic or group practice (PA Group)
71 = Registered Dietician/Nutrition Professional (eff. 1/2002)
72 = Pain Management (eff. 1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug stores)
88 = Unknown provider
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/2001/2006). Prior to 07/2001/2006, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecological/oncology
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = Skilled nursing facility (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)

A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2007)
B2 = Pedorthic Personnel (eff. 10/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and hyperbaric medicine
D5 = Opioid treatment program (eff. 1/2020)
D7 = Micrographic dermatologic surgery (MDS) (eff. 10/2020)
D8 = Adult congenital heart disease
E1 = Marriage and family therapists
E2 = Mental health counselors
E3 = Dental anesthesiology
E4 = Dental public health
E5 = Endodontics
E6 = Oral and maxillofacial pathology
E7 = Oral and maxillofacial radiology
E9 = Oral medicine
F1 = Orofacial pain
F2 = Orthodontics and dentofacial orthopedics
F3 = Pediatric dentistry
F4 = Periodontics
F5 = Prosthodontics

COMMENT: The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physician is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.

^ Back to TOC ^

OT_PHYSN_UPIN

LABEL: Claim Other Physician UPIN Number

DESCRIPTION: On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.

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

SHORT NAME: OT_UPIN

LONG NAME: OT_PHYSN_UPIN

TYPE: CHAR

LENGTH: 6

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

OWNG_PRVDR_TIN_NUM

LABEL: Owning Provider Tax Identification Number (TIN)

DESCRIPTION: The tax identification number (TIN) of the hospital provider used to identify ownership. Medicare's three-day (or one-day) payment window applies to outpatient services furnished by hospitals and hospitals wholly owned or wholly operated Part B entities.

SHORT NAME: OWNG_PRVDR_TIN_NUM

LONG NAME: OWNG_PRVDR_TIN_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated prior to 2021. Applies to hospital, types of bill (TOBs) 011x, 013x, and 014x, claims transmitted to CWF on Effective and Term dates, when the Ownership type equals "1" (Hospital TIN is Owner) or "2" (Owned by different Hospital TIN). The Medicare contractor shall pass to CWF the Provider's TIN in the "Owning TIN" field, when the "Ownership Type" field is blank, with all hospital 011x claims transmitted to CWF on Effective and Term dates.

The TOB is the concatenation of two variables:

Facility type (CLM_FAC_TYPE_CD)

Service classification type (CLM_SRVC_CLSFCTN_TYPE_CD).

^ Back to TOC ^

PHYSN_ZIP_CD

LABEL: Line Place of Service (POS) Physician Zip Code

DESCRIPTION: The 9-digit zip code for the primary practice/business location of the physician receiving the payment or other transfer of value.

SHORT NAME: PHYSN_ZIP_CD

LONG NAME: PHYSN_ZIP_CD

TYPE: CHAR

LENGTH: 15

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

PPS_STD_VAL_PYMT_AMT

LABEL: Standard Payment Amount

DESCRIPTION: This amount identifies the standardized Medicare payment amount.

SHORT NAME: PPS_STD_VAL_PYMT_AMT

LONG NAME: PPS_STD_VAL_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This is the standardized amount as determined by PRICER software output. This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the hospitals.

This field is new in October 2014. This field applied only to inpatient claims until July 2018, when it also applied to home health agency (HHA) claims. For HHA claims, this field was initially called FINL_STD_AMT in the CCW RIF.

NOTE: An additional field is available that further adjusts the standard Medicare Payment amount by applying additional standardization requirements (e.g., sequestration). Refer to variable called the final standardized amount (FINL_STD_AMT).

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PRCDR_DT1

PRCDR_DT2

PRCDR_DT3

PRCDR_DT4

PRCDR_DT5

PRCDR_DT6

PRCDR_DT7

PRCDR_DT8

PRCDR_DT9

PRCDR_DT10

PRCDR_DT11

PRCDR_DT12

PRCDR_DT13

PRCDR_DT14

PRCDR_DT15

PRCDR_DT16

PRCDR_DT17

PRCDR_DT18

PRCDR_DT19

PRCDR_DT20

PRCDR_DT21

PRCDR_DT22

PRCDR_DT23

PRCDR_DT24

PRCDR_DT25

LABEL: Claim Procedure Code Date

DESCRIPTION: The date on which the procedure was performed. The date associated with the procedure identified in the corresponding ICD_PRCDR_CD#.

SHORT NAME:

PRCDR_DT1
PRCDR_DT2
PRCDR_DT3
PRCDR_DT4
PRCDR_DT5
PRCDR_DT6
PRCDR_DT7
PRCDR_DT8
PRCDR_DT9
PRCDR_DT10
PRCDR_DT11
PRCDR_DT12
PRCDR_DT13
PRCDR_DT14
PRCDR_DT15
PRCDR_DT16
PRCDR_DT17
PRCDR_DT18
PRCDR_DT19
PRCDR_DT20
PRCDR_DT21
PRCDR_DT22
PRCDR_DT23
PRCDR_DT24
PRCDR_DT25

LONG NAME:

PRCDR_DT1
PRCDR_DT2
PRCDR_DT3
PRCDR_DT4
PRCDR_DT5
PRCDR_DT6
PRCDR_DT7
PRCDR_DT8

PRCDR_DT9
PRCDR_DT10
PRCDR_DT11
PRCDR_DT12
PRCDR_DT13
PRCDR_DT14
PRCDR_DT15
PRCDR_DT16
PRCDR_DT17
PRCDR_DT18
PRCDR_DT19
PRCDR_DT20
PRCDR_DT21
PRCDR_DT22
PRCDR_DT23
PRCDR_DT24
PRCDR_DT25

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

PRF_PHYSN_NPI

LABEL: Carrier Line Performing NPI Number

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

SHORT NAME: PRFNPI

LONG NAME: PRF_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Effective May 2007, the NPI became the national standard identifier for covered health care providers. NPIs replaced the legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

The UPIN is almost never populated after 2009.

^ Back to TOC ^

PRF_PHYSN_UPIN

LABEL: Carrier Line Performing UPIN Number

DESCRIPTION: The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC).

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

SHORT NAME: PRF_UPIN

LONG NAME: PRF_PHYSN_UPIN

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

^ 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).

SHORT NAME: PRNCPAL_DGNS_CD

LONG NAME: PRNCPAL_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

Effective with version "J," this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

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

^ 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.

SHORT NAME: PRNCPAL_DGNS_VRSN_CD

LONG NAME: PRNCPAL_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

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

^ Back to TOC ^

PRTCPTNG_IND_CD

LABEL: Line Provider Participating Indicator Code

DESCRIPTION: Code indicating whether or not a provider is participating (accepting assignment) for this line-item service on the non-institutional claim.

SHORT NAME: PRTCPTG

LONG NAME: PRTCPTNG_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
1 = Participating
2 = All or some covered and allowed expenses applied to deductible participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some covered and allowed expenses applied to deductible non-participating
6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating
7 = Participating provider not accepting assignment

COMMENT: —

^ Back to TOC ^

PRVDR_FULL_CCN_NUM

LABEL: Full CMS Certification Number for Provider

DESCRIPTION: This variable is the extended CMS Certification Number (CCN).

This extended field is designed to allow for the identification of multiple campus hospitals. For multi-campus hospitals, all campuses contain the same first 6-digit CCN (reference PRVDR_NUM variable in this data file), but positions 7–13 may be used to distinguish between campuses (ex. 01, 02, 001, 002, A, etc.) In the future positions 7–13 may have other uses.

SHORT NAME: PRVDR_FULL_CCN_NUM

LONG NAME: PRVDR_FULL_CCN_NUM

TYPE: CHAR

LENGTH: 13

SOURCE: NCH (derived)

VALUES: —

COMMENT: NCH will continue to map the positions 1–6 of the provider number to the provider number (PRVDR_NUM) field.

This field is not populated prior to 2021.

^ Back to TOC ^

PRVDR_NPI

LABEL: DMERC Line-Item Supplier NPI Number

DESCRIPTION: The National Provider Identifier (NPI) assigned to the supplier of the Part B service/DMEPOS line item.

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

SHORT NAME: SUP_NPI

LONG NAME: PRVDR_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

PRVDR_NUM (Institutional claim)

LABEL: Provider Number

DESCRIPTION: This variable is the provider identification number of the institutional provider certified by Medicare to provide services to the beneficiary. This is the CMS Certification Number (CCN).

The first two digits indicate the state where the provider is located. As two-digit state codes have been exhausted, CMS has implemented a two-position alpha-numeric coding system for state Codes (reference the note in the VALUES below). The middle two characters indicate the type of provider; and the last two digits are used as a counter for the number of providers within that state and type of provider (i.e., this is a unique but not necessarily sequential number).

SHORT NAME: PROVIDER

LONG NAME: PRVDR_NUM

TYPE: CHAR

LENGTH: 6

SOURCE: —

VALUES: The first two positions are the CCN state codes. A state may have more than one code. The following is a list of all CMS assigned state codes to be used with the CCN:

00 = Arizona
01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont

48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Idaho
55 = California
56 = Canada and Islands
57 = New York
58 = West Virginia
59 = Mexico
64 = American Samoa
65 = Guam
66 = Commonwealth of the Northern Marianas Islands
67 = Texas
68 = Florida
69 = Florida
70 = Kansas
71 = Louisiana
72 = Ohio
73 = Pennsylvania
74 = Texas
75 = California
76 = Iowa
77 = Minnesota
78 = Illinois
79 = Missouri
80 = Maryland
81 = Connecticut
82 = Massachusetts
83 = New Jersey
84 = Puerto Rico
85 = Georgia
86 = North Carolina
87 = South Carolina
88 = Tennessee
89 = Arkansas
90 = Oklahoma
91 = Colorado
92 = California
93 = Oregon
94 = Washington
95 = Louisiana
96 = New Mexico
97 = Texas
98 = Hawaii
99 = Foreign Countries (exceptions: Canada and Mexico)
A0 = California
A1 = California
A2 = Florida
A3 = Louisiana
A4 = Michigan
A5 = Mississippi
A6 = Ohio
A7 = Pennsylvania
A8 = Tennessee
A9 = Texas
B0 = Kentucky
B1 = West Virginia
B2 = California
B3 = California
B4 = California
B5 = California
B6 = North Carolina
B7 = Alabama
B8 = Commonwealth of the Northern Marianas Islands
B9 = Delaware
C0 = District of Columbia
C1 = Florida
C2 = Georgia
C3 = Guam
C4 = Illinois
C5 = Indiana
C6 = Maine
C7 = Michigan
C8 = Mississippi
C9 = Missouri
D0 = Nebraska
D1 = New York
D2 = Ohio
D3 = Pennsylvania
D4 = South Carolina
D5 = Virginia
D6 = California
D7 = California
D8 = California
D9 = Arizona
E1 = Nevada
E2 = Texas
E3 = Texas

The following blocks of numbers are reserved for the facilities indicated

(**NOTE:** may have different meanings dependent on the type of bill [TOB]):

0001–0879: Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X

0880–0899: Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X

0900–0999: Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X

1000–1199: Federally Qualified Health Centers (FQHC) (also CCN range 1800–1989)

1200–1224: Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X

1225–1299: Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X

1300–1399: Critical Access Hospitals (CAH)

1400–1499: Continuation of community mental health centers (CMHC) (also CCN ranges 4600–4799 and 4900–4999 series)

1500–1799: Hospices

1800–1989: Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X. (FQHCs are also CCN range 1000–1199)

1990–1999: Religious Nonmedical Health Care Institutions (RNHCI)

2000–2299: Long-term hospitals

2300–2499: Chronic renal disease facilities (hospital based)

2500–2899: Independent (Non-hospital) renal disease facilities

2900–2999: Independent special purpose renal dialysis facility (1)

3000–3024: Formerly tuberculosis hospitals (numbers retired)

3025–3099: Rehabilitation hospitals (Excluded from IPPS)

3100–3199 Home Health Agencies (HHA) (also CCN ranges 7000–8499 and 9000–9799)

3200–3299: Continuation of Comprehensive Outpatient Rehabilitation Facilities (CORF) (also CCN ranges 4500–4599 and of 4800–4899 series)

3300–3399: Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X

3400–3499: Continuation of rural health clinics (RHC) (provider-based) (also CCN ranges 3975–3999 and 8500–8899)

3500–3699: Renal disease treatment centers (hospital satellites)

3700–3799: Hospital based special purpose renal dialysis facility (1)

3800–3974: Rural health clinics (RHC) (free-standing) (also CCN range 8900–8999)

3975–3999: Rural health clinics (RHC) (provider-based) (also CCN ranges 3400-3499 and 8500–8899)

4000–4499: Psychiatric hospitals (Excluded from IPPS)

4500–4599: Comprehensive outpatient Rehabilitation Facilities (CORF) (also CCN ranges 3200–3299 and 4800–4899)

4600–4799: Community Mental Health Centers (CMHC) (also CCN ranges 1400–1499 and 4900–4999)

4800–4899: Continuation of Comprehensive Outpatient Rehabilitation Facilities (CORF) (also CCN ranges 3200–3299 and 4500–4599)

4900–4999: Continuation of Community Mental Health Centers (also CCN ranges 1400–1499 and 4600–4799)

5000–6499: Skilled Nursing Facilities

6500–6989: CMHC/outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X

6990–6999: Numbers Reserved (formerly Christian Science)

7000–7299: Continuation of Home health Agencies (HHA) (also CCN ranges 3100–3199 and 9000–9799)

7300–7399: Subunits of "nonprofit" and "proprietary" Home health Agencies (3)

7400–7799: Continuation of 7000–7299 series

7800–7999: Subunits of state and local governmental home health agencies (3)

8000–8499: Continuation of 7400–7799 series (HHA)

8500–8899: Continuation of rural health clinics (RHC) (provider based) (also CCN ranges 3400–3499 and 3975–3999)

8900–8999: Continuation of rural health clinics (RHC) (free-standing) (also CCN range 3800–3974)

9000–9799: Continuation of Home Health Agencies (HHA) (also CCN ranges 3100-3199 and 8000–8499)

9800–9899: Transplant Centers (eff. 10/1/2007)

9900-9999: Freestanding Opioid Treatment Program (eff. 1/2021)

NOTE: There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

M = Psychiatric Unit in Critical Access Hospital (CAH)

R = Rehabilitation Unit in Critical Access Hospital (CAH)

S = Psychiatric unit of a short-term, cancer, children's, LTCH, or rehabilitation hospital

T = Rehabilitation unit of a short-term, cancer, children's, LTCH, or psychiatric hospital

U = Swing-Bed approval for short-term hospitals

V = Alcohol drug unit (prior to 10/87 only)

W = Swing-Bed approval for long-term care hospitals

Y = Swing-Bed Hospital Designation for Rehabilitation Hospitals (retired value)

Z = Swing Bed approval for Critical Access Hospitals (CAH)

There is also a special numbering system for assigning emergency hospital identification numbers (non-participating hospitals).

The sixth position of the provider number is as follows:

E = Non-federal emergency hospital

F = Federal emergency hospital

COMMENT: Effective October 1, 2007, the OSCAR Provider Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider Identifier (NPI). The CCN will continue to play a critical role in verifying that a provider has been Medicare certified and for what type of services.

Refer to CCW Technical Guidance document: “Getting Started with Medicare Data” for additional information regarding service setting classifications.

If you want additional information about the institutional provider, the quarterly CMS Provider of Services (POS) file contains dozens of variables that describe the characteristics of the provider. This file is updated quarterly, and effective May 2014 is available for free online from the CMS website (2005–current).

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PRVDR_NUM (DMERC claim)

LABEL: DMERC Line Supplier Provider Number

DESCRIPTION: The billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.

SHORT NAME: SUPLRNUM

LONG NAME: PRVDR_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: Different types of identifiers may be used. Refer to the variable called DMERC_LINE_SUPPLR_TYPE_CD to determine the type used for each line.

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PRVDR_SPCLTY

LABEL: Line CMS Provider Specialty Code

DESCRIPTION: CMS (previously called HCFA) specialty code used for pricing the line-item service on the non-institutional claim.

Assigned by the Medicare Administrative Contractor (MAC) based on the corresponding provider identification number (performing NPI or UPIN).

SHORT NAME: HCFASPCL

LONG NAME: PRVDR_SPCLTY

TYPE: CHAR

LENGTH: 3

SOURCE: NCH

VALUES:

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional pain management (IPM) (eff. 4/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathology
16 = Obstetrics/gynecology
17 = Hospice and palliative care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = General psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist assistants (eff. 4/2003 — previously grouped with Certified Registered Nurse Anesthetists [CRNA])
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometrist
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist assistants were removed from this specialty 4/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology

47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Medical supply company with registered pharmacist
59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (private practice added 4/2003) (independently practicing removed 4/2003)
66 = Rheumatology
67 = Occupational therapist (private practice added 4/2003) (independently practicing removed 4/2003)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or multispecialty clinic or group practice
71 = Registered Dietician/Nutrition Professional (eff. 1/2002)
72 = Pain Management (eff. 1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug and department stores)
88 = Unknown supplier/provider specialty
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/2001/2006). Prior to 07/2001/2006, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant

98 = Gynecologist/oncologist
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = SNF (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (his), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2007)
B2 = Pedorthic Personnel (eff. 10/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist
C6 = Hospitalist
C7 = Advanced Heart Failure and Transplant Cardiology
C8 = Medical Toxicology
C9 = Hematopoietic Cell Transplantation and Cellular Therapy
D3 = Medical Genetics and Genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery
D8 = Adult Congenital Heart Disease
E1 = Marriage and Family Therapists
E2 = Mental Health Counselors
E3 = Dental Anesthesiology
E4 = Dental Public Health
E5 = Endodontics
E6 = Oral and Maxillofacial Pathology
E7 = Oral and Maxillofacial Radiology
E9 = Oral Medicine
F1 = Orofacial Pain
F2 = Orthodontics and Dentofacial Orthopedics
F3 = Pediatric Dentistry
F4 = Periodontics
F5 = Prosthodontics

COMMENT: —

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PRVDR_STATE_CD

LABEL: NCH Provider SSA State Code

DESCRIPTION: The two-digit numeric social security administration (SSA) state code where provider or facility is located.

SHORT NAME: PRSTATE

LONG NAME: PRVDR_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada and Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa

65 = Guam
66 = Commonwealth of the Northern Marianas Islands
97 = Northern Marianas
98 = Guam
99 = Unknown or if county code = 000 then this is American Samoa

COMMENT: As two-digit state codes used for the CMS Certification Number (CCN) (field called the PRVDR_NUM) have been exhausted, CMS implemented a two-position alpha-numeric coding system for State Codes. When this occurs, CMS mapped the alphanumeric codes to these SSA state codes. For example, even though Florida CCNs include the first 2-digits (state codes) 10, 68, 69, and A2, all will have PRVDR_STATE_CD = 10. **NOTE:** Effective July 26, 2024, the following CCN assigned state codes are being added to the derivation rules for the provider state code (D6, D7, D8, D9, E1, E2, E3). If these states codes were received prior to July 26, 2024, they are not mapped to the provider state.

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PRVDR_VLDTN_TYPE_CD

LABEL: Provider Validation Type Code

DESCRIPTION: Provider Validation Type Code

SHORT NAME: PRVDR_VLDTN_TYPE_CD

LONG NAME: PRVDR_VLDTN_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: RP = Rendering Provider
OP = Operating Physician
CP = Ordering/Referring Physician
AP = Attending Physician
FA = Facility

COMMENT: The purpose of the Provider Validation Type field on the claim is to inform Common Working File (CWF) to perform an edit check to ensure that the provider that was submitted on the Prior Authorization (PA) request is the same provider on the claim.

This field was new in April 2019.

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PRVDR_ZIP

LABEL: Carrier Line Performing Provider ZIP Code

DESCRIPTION: The ZIP code of the physician/supplier who performed the Part B service for this line item on the carrier claim (non-DMERC).

SHORT NAME: PROVZIP

LONG NAME: PRVDR_ZIP

TYPE: CHAR

LENGTH: 9

SOURCE: NCH

VALUES: —

COMMENT: —

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PTNT_DSCHRG_STUS_CD

LABEL: Patient Discharge Status Code

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

SHORT NAME: STUS_CD

LONG NAME: PTNT_DSCHRG_STUS_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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RC_MODEL_REIMBRSMT_AMT

LABEL: Revenue Center Model Reimbursement Amount

DESCRIPTION: This field is used to identify the “net reimbursement amount” of what Medicare would have paid for the global budget service reflected at the line level, from a hospital participating in the particular model.

SHORT NAME: RC_PTNT_ADD_ON_PYMT_AMT

LONG NAME: RC_PTNT_ADD_ON_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

COMMENT: This field is new in January 2020. This field only applies to Part A claims.

For participating hospitals within the PA model all inpatient and outpatient services (facility/technical services) are considered a part of the model/global budget services. Basically, all the services for participating hospitals would be global except for CAH Method II (where the bill type is 85X) claims lines with revenue codes 096x, 097x, or 098x. The CAH Method II professional services (REV codes 096x, 097x, or 098x) process as they do today, they have nothing to do with the model.

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RC_PTNT_ADD_ON_PYMT_AMT

LABEL: Revenue Center Patient/Initial Visit Add-On Payment Amount (for initial wellness visit)

DESCRIPTION: This field is the revenue-center Patient Initial Visit Add-On Amount. This field represents a base rate increase factor of 1.3516 for new patient initial preventive physical examination (IPPE) and annual wellness visit.

SHORT NAME: RC_PTNT_ADD_ON_PYMT_AMT

LONG NAME: RC_PTNT_ADD_ON_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is new in October 2014.This field only applies to outpatient claims.

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RC_VLNTRY_SRVC_IND_CD

LABEL: Revenue Center Voluntary Service Indicator Code

DESCRIPTION: Effective with version "L" of the NCH layout, this line level field will be used to identify if the service (procedure code) was voluntary or required.

SHORT NAME: RC_VLNTRY_SRVC_IND_CD

LONG NAME: RC_VLNTRY_SRVC_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: V = A voluntary procedure code
Null/missing = A required procedure code

COMMENT: This field was new in January 2021.

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REV_CNTR

LABEL: Revenue Center Code

DESCRIPTION: The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SHORT NAME: REV_CNTR

LONG NAME: REV_CNTR

TYPE: CHAR

LENGTH: 4

SOURCE: NCH

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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REV_CNTR_1ST_ANSI_CD

LABEL: Revenue Center 1st ANSI Code

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

SHORT NAME: REVANSI1

LONG NAME: REV_CNTR_1ST_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: This code set is an external code set maintained by X12 **https://x12.org/codes**

*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES. List may not be complete or current*******

**********POSITIONS 1 and 2 OF ANSI CODE**********

CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient

CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim

OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment

PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments)

PR = Patient Responsibility — this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing

5 = The procedure code/bill type is inconsistent with the place of service

6 = The procedure code is inconsistent with the patient's age

7 = The procedure code is inconsistent with the patient's sex

8 = The procedure code is inconsistent with the provider type

9 = The diagnosis is inconsistent with the patient's age

10 = The diagnosis is inconsistent with the patient's sex

11 = The diagnosis is inconsistent with the procedure

12 = The diagnosis is inconsistent with the provider type

13 = The date of death precedes the date of service

14 = The date of birth follows the date of service

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

16 = Claim/service lacks information which is needed for adjudication

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete

18 = Duplicate claim/service

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation carrier

20 = Claim denied because this injury/illness is covered by the liability carrier

21 = Claim denied because this injury/illness is the liability of the no-fault carrier

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits

23 = Claim adjusted because charges have been paid by another payer

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

25 = Payment denied. Your Stop loss deductible has not been met

26 = Expenses incurred prior to coverage

27 = Expenses incurred after coverage terminated

28 = Coverage not in effect at the time the service was provided

29 = The time limit for filing has expired

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements

31 = Claim denied as patient cannot be identified as our insured

32 = Our records indicate that this dependent is not an eligible dependent as defined

33 = Claim denied. Insured has no dependent coverage

34 = Claim denied. Insured has no coverage for newborns

35 = Benefit maximum has been reached

36 = Balance does not exceed copayment amount

37 = Balance does not exceed deductible amount

38 = Services not provided or authorized by designated (network) providers

39 = Services denied at the time authorization/pre-certification was requested

40 = Charges do not meet qualifications for emergency/urgent care

41 = Discount agreed to in Preferred Provider contract

42 = Charges exceed our fee schedule or maximum allowable amount

43 = Gramm-Rudman reduction

44 = Prompt-pay discount

45 = Charges exceed your contracted/legislated fee arrangement

46 = This (these) service(s) is(are) not covered

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid

48 = This (these) procedure(s) is(are) not covered

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam

50 = These are non-covered services because this is not deemed a "medical necessity" by the payer

51 = These are non-covered services because this a pre-existing condition

52 = The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/perform the service billed

53 = Services by an immediate relative or a member of the same household are not covered

54 = Multiple physicians/assistants are not covered in this case

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer

56 = Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by payer

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules

60 = Charges for outpatient services with the proximity to inpatient services are not covered

61 = Charges adjusted as penalty for failure to obtain second surgical opinion

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount

70 = Cost outlier amount

71 = Primary Payer amount

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment

75 = Direct Medical Education Adjustment

76 = Disproportionate Share Adjustment

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts

88 = Adjustment amount represents collection against receivable created in prior overpayment

89 = Professional fees removed from charges

90 = Ingredient cost adjustment

91 = Dispensing fee adjustment

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges

95 = Benefits adjusted. Plan procedures not followed

96 = Non-covered charges

97 = Payment is included in allowance for another service/procedure

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party

101 = Predetermination: anticipated payment upon completion of services or claim adjudication

102 = Major medical adjustment

103 = Provider promotional discount (i.e., Senior citizen discount)

104 = Managed care withholding

105 = Tax withholding

106 = Patient payment option/election not in effect

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim

108 = Claim/service reduced because rent/purchase guidelines were not met

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor

110 = Billing date predates service date

111 = Not covered unless the provider accepts assignment

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented

113 = Claim denied because service/procedure was provided outside the United States or as a result of war

114 = Procedure/Product not approved by the Food and Drug Administration

115 = Claim/service adjusted as procedure postponed or canceled

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care

118 = Charges reduced for ESRD network support

119 = Benefit maximum for this time period has been reached

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment

122 = Psychiatric reduction

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s)

126 = Deductible — major Medical

127 = Coinsurance — major Medical

128 = Newborn's services are covered in the mother's allowance

129 = Claim denied — prior processing information appears incorrect

130 = Paper claim submission fee

131 = Claim specific negotiated discount

132 = Prearranged demonstration project adjustment

133 = The disposition of this claim/service is pending further review

134 = Technical fees removed from charges

135 = Claim denied. Interim bills cannot be processed

136 = Claim adjusted. Plan procedures of a prior payer were not followed

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes

138 = Claim/service denied. Appeal procedures not followed, or time limits not met

139 = Contracted funding agreement — subscriber is employed by the provider of services

140 = Patient/Insured health identification number and name do not match

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage

142 = Claim adjusted by the monthly Medicaid patient liability amount

A0 = Patient refund amount

A1 = Claim denied charges

A2 = Contractual adjustment

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount

A5 = Medicare Claim PPS Capital Cost Outlier Amount

A6 = Prior hospitalization or 30-day transfer requirement not met

A7 = Presumptive Payment Adjustment

A8 = Claim denied; ungroupable DRG

B1 = Non-covered visits

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized

B9 = Services not covered because the patient is enrolled in a Hospice

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor

B12 = Services not documented in patients' medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Claim/service denied because only one visit or consultation per physician per day is covered

B15 = Claim/service adjusted because this procedure/service is not paid separately

B16 = Claim/service adjusted because "New Patient" qualifications were not met

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program

W1 = Workers Compensation State Fee Schedule Adjustment

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/2002 and forward.

Valid beginning with NCH weekly process date 7/2000.

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REV_CNTR_1ST_MSP_PD_AMT

LABEL: Revenue Center 1st Medicare Secondary Payer (MSP) Paid Amount

DESCRIPTION: The amount paid by the primary payer when the payer is primary to Medicare (Medicare is a secondary).

SHORT NAME: REV_MSP1

LONG NAME: REV_CNTR_1ST_MSP_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/2002 and forward.

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REV_CNTR_2ND_ANSI_CD

LABEL: Revenue Center 2nd ANSI Code

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

SHORT NAME: REVANSI2

LONG NAME: REV_CNTR_2ND_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: *******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******

**********POSITIONS 1 and 2 OF ANSI CODE**********

CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient

CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim

OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment

PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments)

PR = Patient Responsibility — this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing

5 = The procedure code/bill type is inconsistent with the place of service

6 = The procedure code is inconsistent with the patient's age

7 = The procedure code is inconsistent with the patient's sex

8 = The procedure code is inconsistent with the provider type

9 = The diagnosis is inconsistent with the patient's age

10 = The diagnosis is inconsistent with the patient's sex

11 = The diagnosis is inconsistent with the procedure

12 = The diagnosis is inconsistent with the provider type

13 = The date of death precedes the date of service

14 = The date of birth follows the date of service

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

16 = Claim/service lacks information which is needed for adjudication

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete

18 = Duplicate claim/service

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation carrier

20 = Claim denied because this injury/illness is covered by the liability carrier

21 = Claim denied because this injury/illness is the liability of the no-fault carrier

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits

23 = Claim adjusted because charges have been paid by another payer

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

25 = Payment denied. Your Stop loss deductible has not been met

26 = Expenses incurred prior to coverage

27 = Expenses incurred after coverage terminated

28 = Coverage not in effect at the time the service was provided

29 = The time limit for filing has expired

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements

31 = Claim denied as patient cannot be identified as our insured

32 = Our records indicate that this dependent is not an eligible dependent as defined

33 = Claim denied. Insured has no dependent coverage

34 = Claim denied. Insured has no coverage for newborns

35 = Benefit maximum has been reached

36 = Balance does not exceed copayment amount

37 = Balance does not exceed deductible amount

38 = Services not provided or authorized by designated (network) providers

39 = Services denied at the time authorization/pre-certification was requested

40 = Charges do not meet qualifications for emergency/urgent care

41 = Discount agreed to in Preferred Provider contract

42 = Charges exceed our fee schedule or maximum allowable amount

43 = Gramm-Rudman reduction

44 = Prompt-pay discount

45 = Charges exceed your contracted/legislated fee arrangement

46 = This (these) service(s) is(are) not covered

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid

48 = This (these) procedure(s) is(are) not covered

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam

50 = These are non-covered services because this is not deemed a "medical necessity" by the payer

51 = These are non-covered services because this a pre-existing condition

52 = The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/perform the service billed

53 = Services by an immediate relative or a member of the same household are not covered

54 = Multiple physicians/assistants are not covered in this case

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer

56 = Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by payer

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules

60 = Charges for outpatient services with the proximity to inpatient services are not covered

61 = Charges adjusted as penalty for failure to obtain second surgical opinion

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount

70 = Cost outlier amount

71 = Primary Payer amount

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment

75 = Direct Medical Education Adjustment

76 = Disproportionate Share Adjustment

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts

88 = Adjustment amount represents collection against receivable created in prior overpayment

89 = Professional fees removed from charges

90 = Ingredient cost adjustment

91 = Dispensing fee adjustment

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges

95 = Benefits adjusted. Plan procedures not followed

96 = Non-covered charges

97 = Payment is included in allowance for another service/procedure

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party

101 = Predetermination: anticipated payment upon completion of services or claim adjudication

102 = Major medical adjustment

103 = Provider promotional discount (i.e., senior citizen discount)

104 = Managed care withholding

105 = Tax withholding

106 = Patient payment option/election not in effect

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim

108 = Claim/service reduced because rent/purchase guidelines were not met

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor

110 = Billing date predates service date

111 = Not covered unless the provider accepts assignment

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented

113 = Claim denied because service/procedure was provided outside the United States or as a result of war

114 = Procedure/Product not approved by the Food and Drug Administration

115 = Claim/service adjusted as procedure postponed or canceled

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care

118 = Charges reduced for ESRD network support

119 = Benefit maximum for this time period has been reached

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment

122 = Psychiatric reduction

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s)

126 = Deductible — Major Medical

127 = Coinsurance — Major Medical

128 = Newborn's services are covered in the mother's allowance

129 = Claim denied — prior processing information appears incorrect

130 = Paper claim submission fee

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment

133 = The disposition of this claim/service is pending further review

134 = Technical fees removed from charges

135 = Claim denied. Interim bills cannot be processed

136 = Claim adjusted. Plan procedures of a prior payer were not followed

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes

138 = Claim/service denied. Appeal procedures not followed, or time limits not met

139 = Contracted funding agreement — subscriber is employed by the provider of services

140 = Patient/Insured health identification number and name do not match

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage

142 = Claim adjusted by the monthly Medicaid patient liability amount

A0 = Patient refund amount

A1 = Claim denied charges

A2 = Contractual adjustment

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount

A6 = Prior hospitalization or 30-day transfer requirement not met

A7 = Presumptive Payment Adjustment

A8 = Claim denied; ungroupable DRG

B1 = Non-covered visits

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized

B9 = Services not covered because the patient is enrolled in a hospice

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor

B12 = Services not documented in patients' medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Claim/service denied because only one visit or consultation per physician per day is covered

B15 = Claim/service adjusted because this procedure/service is not paid separately

B16 = Claim/service adjusted because "New Patient" qualifications were not met

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program

W1 = Workers Compensation State Fee Schedule Adjustment

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/2000.

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REV_CNTR_2ND_MSP_PD_AMT

LABEL: Revenue Center 2nd Medicare Secondary Payer (MSP) Paid Amount

DESCRIPTION: The amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

SHORT NAME: REV_MSP2

LONG NAME: REV_CNTR_2ND_MSP_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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REV_CNTR_3RD_ANSI_CD

LABEL: Revenue Center 3rd ANSI Code

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

SHORT NAME: REVANSI3

LONG NAME: REV_CNTR_3RD_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: *******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******

**********POSITIONS 1 and 2 OF ANSI CODE**********

CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim

OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment

PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments)

PR = Patient Responsibility — this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing

5 = The procedure code/bill type is inconsistent with the place of service

6 = The procedure code is inconsistent with the patient's age

7 = The procedure code is inconsistent with the patient's sex

8 = The procedure code is inconsistent with the provider type

9 = The diagnosis is inconsistent with the patient's age

10 = The diagnosis is inconsistent with the patient's sex

11 = The diagnosis is inconsistent with the procedure

12 = The diagnosis is inconsistent with the provider type

13 = The date of death precedes the date of service

14 = The date of birth follows the date of service

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

16 = Claim/service lacks information which is needed for adjudication

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete

18 = Duplicate claim/service

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation carrier

20 = Claim denied because this injury/illness is covered by the liability carrier

21 = Claim denied because this injury/illness is the liability of the no-fault carrier

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits

23 = Claim adjusted because charges have been paid by another payer

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

25 = Payment denied. Your Stop loss deductible has not been met

26 = Expenses incurred prior to coverage

27 = Expenses incurred after coverage terminated

28 = Coverage not in effect at the time the service was provided

29 = The time limit for filing has expired

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements

31 = Claim denied as patient cannot be identified as our insured

32 = Our records indicate that this dependent is not an eligible dependent as defined

33 = Claim denied. Insured has no dependent coverage

34 = Claim denied. Insured has no coverage for newborns

35 = Benefit maximum has been reached

36 = Balance does not exceed copayment amount

37 = Balance does not exceed deductible amount

38 = Services not provided or authorized by designated (network) providers

39 = Services denied at the time authorization/pre-certification was requested

40 = Charges do not meet qualifications for emergency/urgent care

41 = Discount agreed to in Preferred Provider contract

42 = Charges exceed our fee schedule or maximum allowable amount

43 = Gramm-Rudman reduction

44 = Prompt-pay discount

45 = Charges exceed your contracted/legislated fee arrangement

46 = This (these) service(s) is(are) not covered

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid

48 = This (these) procedure(s) is(are) not covered

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam

50 = These are non-covered services because this is not deemed a "medical necessity" by the payer

51 = These are non-covered services because this a pre-existing condition

52 = The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/perform the service billed

53 = Services by an immediate relative or a member of the same household are not covered

54 = Multiple physicians/assistants are not covered in this case

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer

56 = Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by payer

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules

60 = Charges for outpatient services with the proximity to inpatient services are not covered

61 = Charges adjusted as penalty for failure to obtain second surgical opinion

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount

70 = Cost outlier amount

71 = Primary Payer amount

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment

75 = Direct Medical Education Adjustment

76 = Disproportionate Share Adjustment

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts

88 = Adjustment amount represents collection against receivable created in prior overpayment

89 = Professional fees removed from charges

90 = Ingredient cost adjustment

91 = Dispensing fee adjustment

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges

95 = Benefits adjusted. Plan procedures not followed

96 = Non-covered charges

97 = Payment is included in allowance for another service/procedure

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party

101 = Predetermination: anticipated payment upon completion of services or claim adjudication

102 = Major medical adjustment

103 = Provider promotional discount (i.e., Senior citizen discount).

104 = Managed care withholding

105 = Tax withholding

106 = Patient payment option/election not in effect

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim

108 = Claim/service reduced because rent/purchase guidelines were not met

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor

110 = Billing date predates service date

111 = Not covered unless the provider accepts assignment

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented

113 = Claim denied because service/procedure was provided outside the United States or as a result of war

114 = Procedure/Product not approved by the Food and Drug Administration

115 = Claim/service adjusted as procedure postponed or canceled

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care

118 = Charges reduced for ESRD network support

119 = Benefit maximum for this time period has been reached

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment

122 = Psychiatric reduction

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s)

126 = Deductible — Major Medical

127 = Coinsurance — Major Medical

128 = Newborn's services are covered in the mother's allowance

129 = Claim denied — prior processing information appears incorrect

130 = Paper claim submission fee

131 = Claim specific negotiated discount

132 = Prearranged demonstration project adjustment

133 = The disposition of this claim/service is pending further review

134 = Technical fees removed from charges

135 = Claim denied. Interim bills cannot be processed

136 = Claim adjusted. Plan procedures of a prior payer were not followed

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes

138 = Claim/service denied. Appeal procedures not followed, or time limits not met

139 = Contracted funding agreement — subscriber is employed by the provider of services

140 = Patient/Insured health identification number and name do not match

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage

142 = Claim adjusted by the monthly Medicaid patient liability amount

A0 = Patient refund amount

A1 = Claim denied charges

A2 = Contractual adjustment

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount

A5 = Medicare Claim PPS Capital Cost Outlier Amount

A6 = Prior hospitalization or 30-day transfer requirement not met

A7 = Presumptive Payment Adjustment

A8 = Claim denied; ungroupable DRG

B1 = Non-covered visits

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized

B9 = Services not covered because the patient is enrolled in a hospice

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor

B12 = Services not documented in patients' medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Claim/service denied because only one visit or consultation per physician per day is covered

B15 = Claim/service adjusted because this procedure/service is not paid separately

B16 = Claim/service adjusted because "New Patient" qualifications were not met

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program

W1 = Workers Compensation State Fee Schedule Adjustment

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/2002 and forward.

Valid beginning with NCH weekly process date 7/2000.

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REV_CNTR_4TH_ANSI_CD

LABEL: Revenue Center 4th ANSI Code

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

SHORT NAME: REVANSI4

LONG NAME: REV_CNTR_4TH_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: *******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******

**********POSITIONS 1 and 2 OF ANSI CODE**********

CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility — this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing

5 = The procedure code/bill type is inconsistent with the place of service

6 = The procedure code is inconsistent with the patient's age

7 = The procedure code is inconsistent with the patient's sex

8 = The procedure code is inconsistent with the provider type

9 = The diagnosis is inconsistent with the patient's age

10 = The diagnosis is inconsistent with the patient's sex

11 = The diagnosis is inconsistent with the procedure

12 = The diagnosis is inconsistent with the provider type

13 = The date of death precedes the date of service

14 = The date of birth follows the date of service

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

16 = Claim/service lacks information which is needed for adjudication

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete

18 = Duplicate claim/service

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation carrier

20 = Claim denied because this injury/illness is covered by the liability carrier

21 = Claim denied because this injury/illness is the liability of the no-fault carrier

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits

23 = Claim adjusted because charges have been paid by another payer

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

25 = Payment denied. Your Stop loss deductible has not been met

26 = Expenses incurred prior to coverage

27 = Expenses incurred after coverage terminated

28 = Coverage not in effect at the time the service was provided

29 = The time limit for filing has expired

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements

31 = Claim denied as patient cannot be identified as our insured

32 = Our records indicate that this dependent is not an eligible dependent as defined

33 = Claim denied. Insured has no dependent coverage

34 = Claim denied. Insured has no coverage for newborns

35 = Benefit maximum has been reached

36 = Balance does not exceed copayment amount

37 = Balance does not exceed deductible amount

38 = Services not provided or authorized by designated (network) providers

39 = Services denied at the time authorization/pre-certification was requested

40 = Charges do not meet qualifications for emergency/urgent care

41 = Discount agreed to in Preferred Provider contract

42 = Charges exceed our fee schedule or maximum allowable amount

43 = Gramm-Rudman reduction

44 = Prompt-pay discount

45 = Charges exceed your contracted/legislated fee arrangement

46 = This (these) service(s) is(are) not covered

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid

48 = This (these) procedure(s) is(are) not covered

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam

50 = These are non-covered services because this is not deemed a "medical necessity" by the payer

51 = These are non-covered services because this a pre-existing condition

52 = The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/perform the service billed

53 = Services by an immediate relative or a member of the same household are not covered

54 = Multiple physicians/assistants are not covered in this case

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer

56 = Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by payer

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules

60 = Charges for outpatient services with the proximity to inpatient services are not covered

61 = Charges adjusted as penalty for failure to obtain second surgical opinion

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount

70 = Cost outlier amount

71 = Primary Payer amount

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment

75 = Direct Medical Education Adjustment

76 = Disproportionate Share Adjustment

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts

88 = Adjustment amount represents collection against receivable created in prior overpayment

89 = Professional fees removed from charges

90 = Ingredient cost adjustment

91 = Dispensing fee adjustment

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges

95 = Benefits adjusted. Plan procedures not followed

96 = Non-covered charges

97 = Payment is included in allowance for another service/procedure

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party

101 = Predetermination: anticipated payment upon completion of services or claim adjudication

102 = Major medical adjustment

103 = Provider promotional discount (i.e., Senior citizen discount).

104 = Managed care withholding

105 = Tax withholding

106 = Patient payment option/election not in effect

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim

108 = Claim/service reduced because rent/purchase guidelines were not met

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor

110 = Billing date predates service date

111 = Not covered unless the provider accepts assignment

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented

113 = Claim denied because service/procedure was provided outside the United States or as a result of war

114 = Procedure/Product not approved by the Food and Drug Administration

115 = Claim/service adjusted as procedure postponed or canceled

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care

118 = Charges reduced for ESRD network support

119 = Benefit maximum for this time period has been reached

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment

122 = Psychiatric reduction

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s)

126 = Deductible — Major Medical

127 = Coinsurance — Major Medical

128 = Newborn's services are covered in the mother's allowance

129 = Claim denied — prior processing information appears incorrect

130 = Paper claim submission fee

131 = Claim specific negotiated discount

132 = Prearranged demonstration project adjustment

133 = The disposition of this claim/service is pending further review

134 = Technical fees removed from charges

135 = Claim denied. Interim bills cannot be processed

136 = Claim adjusted. Plan procedures of a prior payer were not followed

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes

138 = Claim/service denied. Appeal procedures not followed, or time limits not met

139 = Contracted funding agreement — subscriber is employed by the provider of services

140 = Patient/Insured health identification number and name do not match

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage

142 = Claim adjusted by the monthly Medicaid patient liability amount

A0 = Patient refund amount

A1 = Claim denied charges

A2 = Contractual adjustment

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount

A5 = Medicare Claim PPS Capital Cost Outlier Amount

A6 = Prior hospitalization or 30-day transfer requirement not met

A7 = Presumptive Payment Adjustment

A8 = Claim denied; ungroupable DRG

B1 = Non-covered visits

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized

B9 = Services not covered because the patient is enrolled in a hospice

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor

B12 = Services not documented in patients' medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Claim/service denied because only one visit or consultation per physician per day is covered

B15 = Claim/service adjusted because this procedure/service is not paid separately

B16 = Claim/service adjusted because "New Patient" qualifications were not met

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program

W1 = Workers Compensation State Fee Schedule Adjustment

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.

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REV_CNTR_ADJUST_GRP_CD

LABEL: Revenue Center Adjustment Group Code

DESCRIPTION: Claim adjustment group code used to categorize a payment adjustment for a claim or claim line. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: REV_CNTR_ADJUST_GRP_CD

LONG NAME: REV_CNTR_ADJUST_GRP_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: CO = Contractual obligation
OA = Other adjustment
PR = Patient responsibility

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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REV_CNTR_ADJUST_RSN_CD

LABEL: Revenue Center Adjustment Reason Code

DESCRIPTION: Claim adjustment reason code used to describe why a claim or claim line was paid differently than billed. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: REV_CNTR_ADJUST_RSN_CD

LONG NAME: REV_CNTR_ADJUST_RSN_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: This is not a comprehensive list of values; refer to website below for current values and descriptions:
94 = Processed in Excess of charges
119 = Benefit maximum for this time period or occurrence has been reached
132 = Prearranged demonstration project adjustment

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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REV_CNTR_APC_HIPPS_CD

LABEL: Revenue Center APC or HIPPS Code

DESCRIPTION: This field contains one of two potential pieces of data; the Ambulatory Payment Classification (APC) code or the Health Insurance prospective payment system (HIPPS) code, which corresponds with the revenue center line for the claim.

The APC codes are used as the basis for payment for outpatient prospective payment (OPPS) service (e.g., Part B institutional). Additional information regarding OPPS is available on the CMS website (reference: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html).

Some Part A claim types (e.g., home health and SNF) use resource groupings, which are similar to case-mix groups, as the basis for payment (e.g., HHRG, SNF RUGs).

For home health (HH) claims, when the revenue center code (variable called REV_CNTR) is 0023, the HHRG is located in this field and is a HIPPS code. This field is only meaningful for a HH claim when CMS determines the claim should be paid using a different HIPPS code than the one submitted by the provider. When this happens, the revised HIPPS code (the one used for payment purposes) appears in this field and the original HIPPS code submitted by the provider remains in the HCPCS_CD field. Otherwise, this variable will always be null or have a value of “00000” for HH revenue center records.

The resource utilization group for the particular revenue center is located in the data field called the APC or HIPPS code variable.

The APC is a four-byte field.

The HIPPS code is a five-byte field (such as 1AFKS).

SHORT NAME: APCHIPPS

LONG NAME: REV_CNTR_APC_HIPPS_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: APC codes can be downloaded from the CMS website (reference: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html)

Examples of APC codes: 0002 = Fine needle Biopsy/Aspiration; 0812 = Carmustine injection

HIPPS codes can be downloaded from the CMS website Prospective Payment Systems page (reference: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html).

1057 = Micromark Tissue Marker (eff. 1/2001)

COMMENT: The APC field is populated for those claims that are required to process through outpatient PPS Pricer.

The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

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REV_CNTR_BENE_PMT_AMT

LABEL: Revenue Center Payment Amount to Beneficiary

DESCRIPTION: The amount paid to the beneficiary for the services reported on the line item.

SHORT NAME: RBENEPMT

LONG NAME: REV_CNTR_BENE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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REV_CNTR_BLOOD_DDCTBL_AMT

LABEL: Revenue Center Blood Deductible Amount

DESCRIPTION: This variable is the dollar amount the beneficiary is responsible for related to the deductible for blood products that appear on the revenue center record.

A deductible amount applies to the first 3 pints of blood (or equivalent units; applies only to whole blood or packed red cells — not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

SHORT NAME: REVBLOOD

LONG NAME: REV_CNTR_BLOOD_DDCTBL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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REV_CNTR_CASH_DDCTBL_AMT

LABEL: Revenue Center Cash Deductible Amount

DESCRIPTION: This variable is the beneficiary's liability under the annual Part B deductible for the revenue center record. The Part B deductible applies to both institutional (e.g., HOP) and non-institutional (e.g., carrier and DME) services.

SHORT NAME: REVDCTBL

LONG NAME: REV_CNTR_CASH_DDCTBL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X, and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/2002 and forward.

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REV_CNTR_COINSRNC_WGE_ADJSTD_C

LABEL: Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount

DESCRIPTION: This variable is the beneficiary's liability for coinsurance for the revenue center record.

Beneficiaries only face coinsurance once they have satisfied Part B's annual deductible, which applies to both institutional (e.g., HOP) and non-institutional (e.g., carrier and DME) services.

For most Part B services, coinsurance equals 20 percent of the allowed amount.

The coinsurance amount is wage adjusted, based on the metropolitan statistical area (MSA) where the provider is located.

SHORT NAME: WAGEADJ

LONG NAME: REV_CNTR_COINSRNC_WGE_ADJSTD_C

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (reference the list of MLN publications at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

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REV_CNTR_CRA_TPNIES_AMT

LABEL: Revenue Center Capital Related Assets Transitional Add-on Payment Amt New and Innovative Equip

DESCRIPTION: Revenue Center Capital Related Assets Adjustment (CRA) Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Amount.

This line level field represents the ESRD PPS add-on payment for capital-related assets (CRA). For eligible CRAs that are home dialysis machines, ESRD facilities will be paid the CRA for TPNIES

SHORT NAME: REV_CNTR_CRA_TPNIES_AMT

LONG NAME: REV_CNTR_CRA_TPNIES_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XXXX

COMMENT: This only appears on outpatient claims. This field is not populated prior to 2021.

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REV_CNTR_DDCTBL_COINSRNC_CD

LABEL: Revenue Center Deductible Coinsurance Code

DESCRIPTION: Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

SHORT NAME: REVDEDCD

LONG NAME: REV_CNTR_DDCTBL_COINSRNC_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
0 = Charges are subject to deductible and coinsurance
1 = Charges are not subject to deductible
2 = Charges are not subject to coinsurance
3 = Charges are not subject to deductible or coinsurance
4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:
M = Override code; EGHP (employer group health plan) services involved
N = Override code; non-EGHP services involved
X = Override code: MSP (Medicare is secondary payer) cost avoided

COMMENT: —

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REV_CNTR_DSCNT_IND_CD

LABEL: Revenue Center Discount Indicator Code

DESCRIPTION: This code represents a factor that specifies the amount of any Ambulatory payment classification (APC) discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of "T". The flag is applicable when more than one significant procedure is performed.

If there is no discounting the factor will be 1.0.

SHORT NAME: DSCNTIND

LONG NAME: REV_CNTR_DSCNT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: *DISCOUNTING FORMULAS*
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D
6 = TD/U
7 = D(1+D)/U
8 = 2.0/U
D = Discounting fraction (currently 0.5)
U = Number of units
T = Terminated procedure discount (currently 0.5)

COMMENT: This field is populated for those claims that are required to process through outpatient prospective payment system (PPS or OPPS) PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

It has been discovered that this field may be populated with data on claims with dates of service prior to 7/2000 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/2000 and forward.

Data has been found in claims with dates of service prior to 7/2000 because the Standard Systems have processed any claim coming in 7/2000 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

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REV_CNTR_DT

LABEL: Revenue Center Date

DESCRIPTION: This is the date of service for the revenue center record.

However, it is populated only for home health claims, hospice claims, and Part B institutional (HOP) claims.

For home health claims, which are paid based on episodes that can last up to 60 days, this variable indicates the dates for the individual visits.

SHORT NAME: REV_DT

LONG NAME: REV_CNTR_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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REV_CNTR_IDE_NDC_UPC_NUM

LABEL: Revenue Center IDE, NDC, or UPC Number

DESCRIPTION: This field may contain one of three types of identifiers: the National Drug Code (NDC), the Universal Product Code (UPC), or the number assigned by the Food and Drug Administration (FDA) to an investigational device (IDE) after the manufacturer has approval to conduct a clinical trial.

The IDEs will have a revenue center code “0624”.

SHORT NAME: IDENDC

LONG NAME: REV_CNTR_IDE_NDC_UPC_NUM

TYPE: CHAR

LENGTH: 24

SOURCE: NCH

VALUES: —

COMMENT: This field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim).

The size of this field was expanded to X(24) to accommodate either of the new fields (under version “H” it was X(7).

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REV_CNTR_NCVRD_CHRG_AMT

LABEL: Revenue Center Non-Covered Charge Amount

DESCRIPTION: The charge amount related to a revenue center code for services that are not covered by Medicare.

SHORT NAME: REV_NCVR

LONG NAME: REV_CNTR_NCVRD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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REV_CNTR_NDC_QTY

LABEL: Revenue Center National Drug Code (NDC) Quantity

DESCRIPTION: Effective with version "J," the quantity dispensed for the drug reflected on the revenue center line item.

SHORT NAME: REV_CNTR_NDC_QTY

LONG NAME: REV_CNTR_NDC_QTY

TYPE: NUM

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: The unit of measurement for the drug that was administered (e.g., grams, liters) is indicated in the variable called REV_CNTR_NDC_QTY_QLFR_CD.

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REV_CNTR_NDC_QTY_QLFR_CD

LABEL: Revenue Center NDC Quantity Qualifier Code

DESCRIPTION: Effective with version "J," the code used to indicate the unit of measurement for the drug that was administered.

SHORT NAME: REV_CNTR_NDC_QTY_QLFR_CD

LONG NAME: REV_CNTR_NDC_QTY_QLFR_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: F2 = International Unit
GR = Gram
ML = Milliliter
UN = Unit

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

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REV_CNTR_OTAF_PMT_CD

LABEL: Revenue Center Obligation to Accept As Full (OTAF) Payment Code

DESCRIPTION: The code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

SHORT NAME: OTAF_1

LONG NAME: REV_CNTR_OTAF_PMT_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: —

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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REV_CNTR_PACKG_IND_CD

LABEL: Revenue Center Packaging Indicator Code

DESCRIPTION: The code used to identify those services that are packaged/bundled with another service.

SHORT NAME: PACKGIND

LONG NAME: REV_CNTR_PACKG_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
0 = Not packaged
1 = Packaged service (service indicator N)
2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem
3 = Artificial charges for surgical procedure (eff. 7/2004)

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code "07" and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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REV_CNTR_PMT_AMT_AMT

LABEL: Revenue Center (Medicare) Payment Amount

DESCRIPTION: To obtain the Medicare payment amount for the services reported on the revenue center record, it is more accurate to use a different variable called the revenue center Medicare provider payment amount (REV_CNTR_PRVDR_PMT_AMT).

For home health, use the claim-level Medicare payment amount (variable that is the total of all revenue center records on the claim, which is called CLM_PMT_AMT), since each visit is not paid separately.

SHORT NAME: REVPMT

LONG NAME: REV_CNTR_PMT_AMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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REV_CNTR_PMT_MTHD_IND_CD

LABEL: Revenue Center Payment Method Indicator Code

DESCRIPTION: The code used to identify how the service is priced for payment.

This field is made up of two pieces of data, 1st position being the status indicator and the 2nd position being the payment indicator.

SHORT NAME: PMTMTHD

LONG NAME: REV_CNTR_PMT_MTHD_IND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

0 = Unknown Value (but present in data)

1 = Paid standard hospital OPPS amount (status indicators J1, J2, R, S, T, U, V)

2 = Services not paid under OPPS Pricer; paid under fee schedule or other payment system (status indicators A, G, K)

3 = Not paid (status indicators Q1, Q2, Q3, Q4, M, W, Y, E1, E2) or not paid under OPPS (status indicators B, C, Z)

4 = Paid at reasonable cost (status indicator F and L)

5 = Paid standard amount for pass-through drug or biological (status indicator G)

6 = Payment based on charge adjusted to cost (status indicator H)

7 = Additional payment for new drug or new biological (status indicator J)

8 = Paid partial hospitalization per diem (status indicator P)

9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services)

10 = Paid FQHC encounter payment

11 = Not paid or not included under FQHC encounter payment

12 = No additional payment, included in payment for FQHC encounter

13 = Paid FQHC encounter payment for New patient or IPPE/AWV

14 = Grandfathered tribal FQHC encounter payment

15 = FQHC IOP encounter payment

16 = Wrap-around payment for FQHCs that contract with Medicare Advantage (MA) organizations

*********VALUES PRIOR TO 10/3/2005**********
**********Service Status Indicator**********
********** 1st position **********

A = Services not paid under OPPS
C = Inpatient procedure
E = Non-covered items or services
F = Corneal tissue acquisition
G = Current drug or biological pass-through
H = Device pass-through
J = New drug or new biological pass-through
N = Packaged incidental service
P = Partial hospitalization services
S = Significant procedure not subject to multiple procedure discounting
T = Significant procedure subject to multiple procedure discounting
V = Medical visit to clinic or emergency department
X = Ancillary service

**********Payment Indicator**********
********** 2nd position **********

1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)

2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)

3 = Not paid (service indicators C and E)

4 = Acquisition cost paid (service indicator F)

5 = Additional payment for current drug or biological (service indicator G)

6 = Additional payment for device (service indicator H)

7 = Additional payment for new drug or new biological (service indicator J)

8 = Paid partial hospitalization per diem (service indicator P)

9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)

COMMENT: Prior to 10/2005, this variable contained the valid values for both the payment indicator and status indicator. Effective 10/2005, only the payment indicator codes remain in this table and the status indicator is housed in a new field named: REV_CNTR_STUS_IND_CD (with the corresponding values in the new table: REV_CNTR_STUS_IND_TB). Both the payment indicator and status indicator values have been expanded to 2-btyes.

This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward. ^ Back to TOC ^

REV_CNTR_PRCNG_IND_CD

LABEL: Revenue Center Pricing Indicator Code

DESCRIPTION: The code used to identify if there was a deviation from the standard method of calculating payment amount.

SHORT NAME: REV_CNTR_PRCNG_IND_CD

LONG NAME: REV_CNTR_PRCNG_IND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.

B = A valid HCPCS code subject to the fee schedule payment. for the provider billed charges. **NOTE:** There is an exception for Critical Access Hospitals (provider numbers XX1300–XX1399) with reimbursement method "J" (all-inclusive method) and dates of service on or after 7/1/2001. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.

C = Unlisted Rehabilitation carrier Priced HCPCS

D = A valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.

E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.

F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS. **NOTE:** The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.

G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.

H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category of DME.

I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.

L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review. This code will be automatically set by the system.

M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months. This must be set by Medical Review. This must be set by Medical Review when approved for payment.

N = Paid based on the fee amount for non ESRD TOB's. **NOTE:** Fee amount is paid regardless of charges.

Q = Manual pricing

R = A valid radiology HCPCS code and is subject to APC. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges.

S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate.

T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.

U = Valid ambulance HCPCS. A fee amount is present. The amount payable is a blended amount based on a percentage of the fee schedule and a percentage of the reasonable cost. The fee amount is subject to coinsurance and deductible.

X = Unclassified drug as subject to manual pricing.

COMMENT: This field is populated for those claims that are required to process through the outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X,13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

It has been discovered that this field may be populated with data on claims with dates of service prior to 7/2000 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the

new revenue center fields was that data would be populated on claims with dates of service 7/2000 and forward. Data has been found in claims with dates of service prior to 7/2000 because the Standard Systems have processed any claim coming in 7/2000 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

VALUES D, U and T REPRESENT THE FOLLOWING:

- D = Discounting fraction (currently 0.5)
- U = Number of units
- T = Terminated procedure discount (currently 0.5)

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REV_CNTR_PRVDR_PMT_AMT

LABEL: Revenue Center (Medicare) Provider Payment Amount

DESCRIPTION: The amount Medicare paid for the services reported on the revenue center record.

This field is rarely populated for Part A claims due to per-diem or DRG payments; the claim payment amounts should be used instead.

For Hospital outpatient services (also called Institutional outpatient claims, which consist of claim type [variable called NCH_CLM_TYPE_CD] = 40), this variable can be summed across all revenue center lines for the claim to obtain the total Medicare claim payment amount.

SHORT NAME: RPRVDPMT

LONG NAME: REV_CNTR_PRVDR_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Additional information regarding claim versus revenue-line level payments can be found in a CCW Technical Guidance document entitled: "Getting Started with Medicare Administrative Data."

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REV_CNTR_PTNT_RSPNSBLTY_PMT

LABEL: Revenue Center Patient Responsibility Payment Amount

DESCRIPTION: The amount paid by the beneficiary to the provider for the line-item service.

SHORT NAME: PTNTRESP

LONG NAME: REV_CNTR_PTNT_RSPNSBLTY_PMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is populated for those claims that are required to process through outpatient PPS software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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REV_CNTR_RATE_AMT

LABEL: Revenue Center Rate Amount

DESCRIPTION: Charges relating to unit cost associated with the revenue center code.

SHORT NAME: REV_RATE

LONG NAME: REV_CNTR_RATE_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: For SNF PPS claims (when revenue center code equals “0022”), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

Under HH PPS (when revenue center code equals “0023”), CMS has developed an HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment.

In cases of SCICs, there will be more than one “0023” revenue center line, each representing the payment made at each case-mix level.

For IRF PPS claims (when revenue center code equals “0024”), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

Exception (encounter data only): If plan (e.g., MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.

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REV_CNTR_RDCD_COINSRNC_AMT

LABEL: Revenue Center Reduced Coinsurance Amount

DESCRIPTION: For all services subject to outpatient prospective payment system (PPS or OPPS), the amount of coinsurance applicable to the line for a particular service (as indicated by the HCPCS code) for which the provider has elected to reduce the coinsurance amount.

SHORT NAME: RDCDCOIN

LONG NAME: REV_CNTR_RDCD_COINSRNC_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS.

These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

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REV_CNTR_RP_IND_CD

LABEL: Revenue Center Representative Payee (RP) Indicator Code

DESCRIPTION: Revenue Center Representative Payee (RP) Indicator Code

SHORT NAME: REV_CNTR_RP_IND_CD

LONG NAME: REV_CNTR_RP_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: R = bypass representative payee

COMMENT: This field is used to designate by-passing of the prior authorization processing for claims with a representative payee when an “R” is present in the field.

This field was new in April 2016.

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REV_CNTR_STUS_IND_CD

LABEL: Revenue Center Status Indicator Code

DESCRIPTION: This variable indicates how the service listed on the revenue center record was priced for payment purposes.

The revenue center status indicator code is most useful with outpatient hospital claims, where multiple methods may be used to determine the payment amount for the various revenue center records on the claim (for example, some lines may be bundled into an APC and paid under the outpatient PPS, while other lines may be paid under other fee schedules).

SHORT NAME: REVSTIND

LONG NAME: REV_CNTR_STUS_IND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

A = Services not paid under OPPS; paid under fee schedule or other payment system (Includes Unclassified drugs and biologicals reportable under HCPCS code C9399)

B = Non-allowed item or service for OPPS; may be paid under a different bill type (e.g., CORF)

C = Inpatient procedure

E = Non-allowed item or service (discontinued 01/01/2017)

E1 = Non-allowed item or service

E2 = Items and services for which pricing information and claims data are not available

F = Corneal tissue acquisition, certain CRNA services

G = Drug/biological pass-through

H = Pass-through device categories

I = Inpatient Rehabilitation Facility (IRF) PPS - Submitted and priced HIPPS/CMG codes are different, changed by IRF PPS PRICER

NOTE: The priced HIPPS/CMG code is displayed on the revenue code 0024 line in the PAY/HCPC/APC CD field when different from the submitted HIPPS/CMG code displayed in the HCPC field

J = New drug or new biological pass-through (discontinued 04/01/2002 and replaced by status indicator G for all drugs/biologicals)

J1 = Hospital Part B services paid through a comprehensive APC; eff. 01/2015)

J2 = Hospital Part B services that may be paid through a comprehensive APC

K = Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals)

L = Influenza Vaccine; Pneumococcal Pneumonia Vaccine; Hepatitis B Vaccines; Covid-19 Vaccine; Monoclonal Antibody Therapy Product

M = Service not billable to fiscal intermediary [now a MAC] (not paid under OPPS); For home health - Medical Review changes a HIPPS code

N = Items and Services packaged into APC rates

P = For Outpatient claims - Partial Hospitalization; For home health - Claim contains less than 10 therapy revenue codes and no medical review intervention

Q = Packaged services subject to separate payment based on payment criteria (discontinued 01/01/2009 and replaced by status indicators Q1, Q2, Q3, Q4)

Q1 STV-Packaged codes

Q2 = T-Packaged codes

Q3 = Codes that may be paid through a composite APC- (eff. 2009)

Q4 = Conditionally packaged laboratory services

R = Blood and blood products

S = Procedure or service, not discounted when multiple

T = Procedure or service, multiple reduction applies

U = Brachytherapy sources

V = Clinic or emergency department visit

W = Invalid HCPCS or invalid revenue code with blank HCPCS

X = Ancillary service (terminated)

Y = Non-implantable DME (e.g., therapeutic shoes)

Z = Valid revenue with blank HCPCS and no other status indicator assigned

COMMENT: This 2-byte indicator was added 10/2005 due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code “07” and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

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REV_CNTR_RA_RMRK_CD

LABEL: Revenue Center Remittance Advice Remark Code

DESCRIPTION: Claim Remittance Advice Remark Code used to provide an additional explanation for an adjustment already described by a claim adjustment reason code (CARC) for a claim or claim line. It is also used to communicate information about remittance processing. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: REV_CNTR_RA_RMRK_CD

LONG NAME: REV_CNTR_RA_RMRK_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: N83 = No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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REV_CNTR_THRPY_RDCTN_AMT

LABEL: Revenue Center Therapy Reduction Amount

DESCRIPTION: This line level field is used to represent the 15% reduction amount for physical therapy assistant (PTA) and occupational therapy assistant (OTA) services when modifiers CO or CQ are present.

SHORT NAME: REV_CNTR_THRPY_RDCTN_AMT

LONG NAME: REV_CNTR_THRPY_RDCTN_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: X.XX

COMMENT: Applies to types of bill (TOB)s; 13x, 22x, 23x, 34x, 74x, and 75x. This only appears on outpatient claims. This field is not populated prior to 2021.

The TOB is the concatenation of two variables:

Facility type (CLM_FAC_TYPE_CD)

Service classification type (CLM_SRVC_CLSFCTN_TYPE_CD).

Effective January 3, 2023, this field will include the Rural Emergency Hospital (REH) 5% payment increase. Applies to claims processed by the outpatient prospective payment system (OPPS), identified by provider type of “24K”, CLM_OP_PPS_IND = 2, and TOBs 13X and 14X.

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REV_CNTR_TOT_CHRG_AMT

LABEL: Revenue Center Total Charge Amount

DESCRIPTION: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.

SHORT NAME: REV_CHRG

LONG NAME: REV_CNTR_TOT_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:

1. For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (i.e., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).
2. For SNF PPS (non-demo claims), when revenue center code = “0022”, the total charges will be zero.
3. For home health PPS (RAPs), when revenue center code = “0023”, the total charges will equal the dollar amount for the “0023” line.
4. For home health PPS (final claim), when revenue center code = “0023”, the total charges will be the sum of the revenue center code lines (other than “0023”).
5. For inpatient Rehabilitation Facility (IRF) PPS, when the revenue center code = “0024”, the total charges will be zero. For accommodation revenue codes (010X–021X), total charges must equal the rate times the units.
6. For encounter data, if the plan (e.g., MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days).

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REV_CNTR_UNIT_CNT

LABEL: Revenue Center Unit Count

DESCRIPTION: A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

SHORT NAME: REV_UNIT

LONG NAME: REV_CNTR_UNIT_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: When revenue center code = “0022” (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

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RFR_PHYSN_NPI

LABEL: Claim Referring Physician NPI Number

DESCRIPTION: The national provider identifier (NPI) number assigned to uniquely identify the referring physician.

SHORT NAME: RFR_PHYSN_NPI*

LONG NAME: RFR_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: * The short SAS name is RFR_NPI in the carrier and DME files

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

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RFR_PHYSN_SPCLTY_CD

LABEL: Claim Referring Physician Specialty Code

DESCRIPTION: The code used to identify the CMS specialty code of the referring physician/practitioner.

SHORT NAME: RFR_PHYSN_SPCLTY_CD

LONG NAME: RFR_PHYSN_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/1/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative medicine
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathologist in private practice
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistant (eff. 4/1/2003 — previously grouped with Certified Registered Nurse Anesthetists (CRNA))
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner

51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotic personnel certified by an accrediting organization
56 = Individual certified prosthetic personnel certified by an accrediting organization
57 = Individual certified prosthetic-orthotic personnel certified by an accrediting organization
58 = Medical supply company with registered pharmacist
59 = Ambulance service (private)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist in private practice
66 = Rheumatology
67 = Occupational therapist in private practice
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or Multispecialty clinic or group practice (PA Group)
71 = Registered Dietician/Nutrition Professional (eff. 1/1/2002)
72 = Pain Management (eff. 1/1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/1/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug stores)
88 = Unknown provider
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/2001/2006). Prior to 07/2001/2006, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecological/oncology
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = Skilled nursing facility (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)

A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2007)
B2 = Pedorthic Personnel (eff. 10/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery (MDS) (eff. 10/2020)
D8 = Adult Congenital Heart Disease
E1 = Marriage and Family Therapists
E2 = Mental Health Counselors
E3 = Dental Anesthesiology
E4 = Dental Public Health
E5 = Endodontics
E6 = Oral and Maxillofacial Pathology
E7 = Oral and Maxillofacial Radiology
E9 = Oral Medicine
F1 = Orofacial Pain
F2 = Orthodontics and Dentofacial Orthopedics
F3 = Pediatric Dentistry
F4 = Periodontics
F5 = Prosthodontics

COMMENT: —

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RFR_PHYSN_UPIN

LABEL: Carrier/DMERC Claim Ordering Physician UPIN Number

DESCRIPTION: The unique physician identification number (UPIN) of the physician who referred the beneficiary or the physician who ordered the Part B services or durable medical equipment (DME).

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

SHORT NAME: RFR_UPIN

LONG NAME: RFR_PHYSN_UPIN

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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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).

SHORT NAME: RLTCNDSQ

LONG NAME: RLT_COND_CD_SEQ

TYPE: CHAR

LENGTH: 3

SOURCE: CCW

VALUES: —

COMMENT: —

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RLT_OCRNC_CD_SEQ

LABEL: Claim Related Occurrence Code Sequence

DESCRIPTION: The sequence number of the claim related occurrence code (variable called CLM_RLT_OCRNC_CD).

SHORT NAME: RLTOCRSQ

LONG NAME: RLT_OCRNC_CD_SEQ

TYPE: CHAR

LENGTH: 3

SOURCE: CCW

VALUES: —

COMMENT: —

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RLT_SPAN_CD_SEQ

LABEL: Claim Related Span Code Sequence

DESCRIPTION: The sequence number of the related span code (variable called CLM_SPAN_CD).

SHORT NAME: RLTSPNSQ

LONG NAME: RLT_SPAN_CD_SEQ

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

VALUES: —

COMMENT: —

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RLT_VAL_CD_SEQ

LABEL: Claim Related Value Code Sequence

DESCRIPTION: The sequence number of the related claim value code (variable called CLM_VAL_CD).

SHORT NAME: RLTVALSQ

LONG NAME: RLT_VAL_CD_SEQ

TYPE: CHAR

LENGTH: 3

SOURCE: CCW

VALUES: —

COMMENT: —

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RNDRNG_PHYSN_NPI

LABEL: Rendering Physician NPI

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

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

SHORT NAME: RNDRNG_PHYSN_NPI

LONG NAME: RNDRNG_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: This field appears on both the revenue center and base claim files.

CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/2007 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no new UPINs (legacy numbers) will be generated for new physicians (Part B and outpatient claims), so there will only be NPIs sent into the NCH for those physicians.

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RNDRNG_PHYSN_SPCLTY_CD

LABEL: Claim or Revenue Center Rendering Physician Specialty Code

DESCRIPTION: The code used to identify the CMS specialty code of the rendering physician/practitioner.

SHORT NAME: RNDRNG_PHYSN_SPCLTY_CD

LONG NAME: RNDRNG_PHYSN_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/1/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative medicine
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathologist in private practice
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistant (eff. 4/1/2003 — previously grouped with Certified Registered Nurse G
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner

51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotic personnel certified by an accrediting organization
56 = Individual certified prosthetic personnel certified by an accrediting organization
57 = Individual certified prosthetic-orthotic personnel certified by an accrediting organization
58 = Medical supply company with registered pharmacist
59 = Ambulance service (private)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist in private practice
66 = Rheumatology
67 = Occupational therapist in private practice
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or Multispecialty clinic or group practice (PA Group)
71 = Registered Dietician/Nutrition Professional (eff. 1/1/2002)
72 = Pain Management (eff. 1/1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/1/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug stores)
88 = Unknown provider
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/2001/2006). Prior to 07/2001/2006, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecological/oncology
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = Skilled nursing facility (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)

A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2007)
B2 = Pedorthic Personnel (eff. 10/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery (MDS) (eff. 10/2020)
D8 = Adult Congenital Heart Disease
E1 = Marriage and Family Therapists
E2 = Mental Health Counselors
E3 = Dental Anesthesiology
E4 = Dental Public Health
E5 = Endodontics
E6 = Oral and Maxillofacial Pathology
E7 = Oral and Maxillofacial Radiology
E9 = Oral Medicine
F1 = Orofacial Pain
F2 = Orthodontics and Dentofacial Orthopedics
F3 = Pediatric Dentistry
F4 = Periodontics
F5 = Prosthodontics

COMMENT: This field appears on both the revenue center and base claim files.

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RNDRNG_PHYSN_UPIN

LABEL: Revenue Center Rendering Physician UPIN

DESCRIPTION: This variable is the unique physician identification number (UPIN) for the physician who rendered the services on the revenue center record.

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

SHORT NAME: RNDRNG_PHYSN_UPIN

LONG NAME: RNDRNG_PHYSN_UPIN

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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RNDRNG_PHYSN_UPIN

LABEL: Revenue Center Rendering Physician UPIN

DESCRIPTION: This variable is the unique physician identification number (UPIN) for the physician who rendered the services on the revenue center record.

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

SHORT NAME: RNDRNG_PHYSN_UPIN

LONG NAME: RNDRNG_PHYSN_UPIN

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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RNDRNG_PRVDR_SPCLTY_CD1

RNDRNG_PRVDR_SPCLTY_CD2

RNDRNG_PRVDR_SPCLTY_CD3

LABEL: Rendering Provider Secondary Specialty Code (1–3)

DESCRIPTION: CMS secondary specialty code(s) for the rendering (aka performing) provider on the non-institutional claim.

Applies to the PRF_PHYSN_NPI on the carrier line file. These rendering provider specialty codes are in addition to the Line CMS Provider Specialty Code (PRVDR_SPCLTY).

SHORT NAME: RNDRNG_PRVDR_SPCLTY_CD1
RNDRNG_PRVDR_SPCLTY_CD2
RNDRNG_PRVDR_SPCLTY_CD3

LONG NAME: RNDRNG_PRVDR_SPCLTY_CD1
RNDRNG_PRVDR_SPCLTY_CD2
RNDRNG_PRVDR_SPCLTY_CD3

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathology
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports Medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = General Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistants (eff. 4/2003 — previously grouped with Certified Registered Nurse Anesthetists [CRNA])
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine

37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometrist
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Medical supply company with registered pharmacist
59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (private practice added 4/1/2003) (independently practicing removed 4/1/2003)
66 = Rheumatology
67 = Occupational therapist (private practice added 4/1/2003) (independently practicing removed 4/1/2003)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or multispecialty clinic or group practice
71 = Registered Dietician/Nutrition Professional (eff. 1/1/2002)
72 = Pain Management (eff. 1/1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/1/2003)
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77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug and department stores)
88 = Unknown supplier/provider specialty
89 = Certified clinical nurse specialist

90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/2001/2006). Prior to 07/2001/2006, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecologist/oncologist
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = SNF (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2007)
B2 = Pedorthic Personnel (eff. 10/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist
C6 = Hospitalist
C7 = Advanced Heart Failure and Transplant Cardiology
C8 = Medical Toxicology
C9 = Hematopoietic Cell Transplantation and Cellular Therapy
D3 = Medical Genetics and Genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery
D8 = Adult Congenital Heart Disease
E1 = Marriage and Family Therapists
E2 = Mental Health Counselors
E3 = Dental Anesthesiology
E4 = Dental Public Health
E5 = Endodontics
E6 = Oral and Maxillofacial Pathology
E7 = Oral and Maxillofacial Radiology
E9 = Oral Medicine
F1 = Orofacial Pain
F2 = Orthodontics and Dentofacial Orthopedics
F3 = Pediatric Dentistry
F4 = Periodontics
F5 = Prosthodontic

COMMENT: These fields were added in October 2023.

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RNDRNG_PRVDR_TXNMY_CD

LABEL: Rendering Provider Taxonomy Code

DESCRIPTION: Rendering provider taxonomy code. Applies to the PRF_PHYSN_NPI on the carrier line file. A taxonomy code is a unique 10-character code that assigns a provider's classification and specialization. Providers use this code when applying for a National Provider Identifier (NPI).

SHORT NAME: RNDRNG_PRVDR_TXNMY_CD

LONG NAME: RNDRNG_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: XXXXXXXXX
Null/missing

COMMENT: There are also rendering provider specialty code fields on the carrier line, including the line CMS provider specialty code (PRVDR_SPCLTY) and three secondary specialty codes (RNDRNG_PRVDR_SPCLTY_CD1–3).

This field was new in October 2023.

This code set is an external code set maintained by the National Uniform Claim Committee (NUCC) (https://www.nucc.org/index.php).

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RR_BRD_EXCLSN_IND_SW

LABEL: Railroad Board Exclusion Indicator Switch

DESCRIPTION: This field indicates whether Railroad Board (RRB) beneficiary claim should be excluded from Prior Authorization processing.

SHORT NAME: RR_BRD_EXCLSN_IND_SW

LONG NAME: RR_BRD_EXCLSN_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes (exclude RRB beneficiary from PA)
Null/missing = Subject RRB beneficiary services to prior authorization

COMMENT: This field informs the SSMs and CWF if the RRB beneficiary claim should either be included or excluded from Prior Authorization (PA) processing. Ex: If the field is valued “Y”, and it is RRB beneficiary claim, it will be excluded from PA processing.

This field was new in April 2019.

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RSN_VISIT_CD1

RSN_VISIT_CD2

RSN_VISIT_CD3

LABEL: Reason for Visit Diagnosis Code

DESCRIPTION: The diagnosis code used to identify the patient's reason for the hospital outpatient visit.

SHORT NAME: RSN_VISIT_CD1
RSN_VISIT_CD2
RSN_VISIT_CD3

LONG NAME: RSN_VISIT_CD1
RSN_VISIT_CD2
RSN_VISIT_CD3

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: Prior to version “J,” this field was: CLM_ADMTG_DGNS_CD.

With version “J,” the name has changed and there can be up to 3 occurrences of this group.

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

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RSN_VISIT_VRSN_CD1

RSN_VISIT_VRSN_CD2

RSN_VISIT_VRSN_CD3

LABEL: Reason for Visit Diagnosis Code Version Code (ICD-9 or ICD-10)

DESCRIPTION: The code used to indicate if the reason for visit diagnosis code is ICD-9 or ICD-10.

SHORT NAME: RSN_VISIT_VRSN_CD1
RSN_VISIT_VRSN_CD1
RSN_VISIT_VRSN_CD1

LONG NAME: RSN_VISIT_VRSN_CD1
RSN_VISIT_VRSN_CD1
RSN_VISIT_VRSN_CD1

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: With 5010, the diagnosis and procedure codes expanded to accommodate ICD-10.

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

This code is associated with the diagnosis code identified in the corresponding RSN_VISIT_CD#.

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SRVC_LOC_NPI_NUM

LABEL: Claim Service Location NPI Number

DESCRIPTION: The National Provider Identifier (NPI) of the location where the services were provided.

SHORT NAME: SRVC_LOC_NPI_NUM

LONG NAME: SRVC_LOC_NPI_NUM

TYPE: CHAR

LENGTH: 22

SOURCE: NCH

VALUES: —

COMMENT: This field was new in January 2014. It is null/missing for all years prior.

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TAX_NUM

LABEL: Line Provider Tax Number

DESCRIPTION: The federal taxpayer identification number (TIN) that identifies the physician/practice/supplier to whom payment is made for the line-item service on the noninstitutional claim.

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

SHORT NAME: TAX_NUM

LONG NAME: TAX_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: For DME claims, all 10 digits are populated. The first 9 digits represent the EIN or SSN, and the final (rightmost) tenth digit indicates the type of provider ID that is used (reference the DMERC_LINE_SUPPLR_TYPE_CD for these values). For all other claim types, only 9 digits of the field are populated.

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THRPY_CAP_IND_CD1

THRPY_CAP_IND_CD2

THRPY_CAP_IND_CD3

THRPY_CAP_IND_CD4

THRPY_CAP_IND_CD5

LABEL: Therapy Cap Indicator Code

DESCRIPTION: The field used to identify whether the claim line (or revenue center) is subject to a therapy cap.

SHORT NAME: THRPY_CAP_IND_CD1
THRPY_CAP_IND_CD2
THRPY_CAP_IND_CD3
THRPY_CAP_IND_CD4
THRPY_CAP_IND_CD5

LONG NAME: THRPY_CAP_IND_CD1
THRPY_CAP_IND_CD2
THRPY_CAP_IND_CD3
THRPY_CAP_IND_CD4
THRPY_CAP_IND_CD5

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator is used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). **NOTE:** Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The $3,700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

COMMENT: This field appears on the revenue center / line files.

In the carrier line file, there are up to five indicators for the therapy cap — reference variables called THRPY_CAP_IND_CD1–THRPY_CAP_IND_CD5. In institutional revenue center files (inpatient, SNF,

hospice, home health, and outpatient), there are two occurrences of this field (THRPY_CAP_IND_CD1–THRPY_CAP_IND_CD2).

Details regarding the therapy cap can be found on the CMS website, under the Medicare therapy services web page (reference, for example: https://www.cms.gov/Medicare/Billing/TherapyServices/index.html).

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TRNSTNL_DRUG_ADD_ON_PYMT_AMT

LABEL: Transitional Drug Add-On Payment Amount

DESCRIPTION: This field houses the amount for the Transitional Drug Add-On Payment Adjustment (TDAPA) for ESRD claims (72X) with injectable, intravenous, and oral calcimimetics when reported with an AX modifier. These services qualify for an add-on payment from the ESRD Pricer.

SHORT NAME: TRNSTNL_DRUG_ADD_ON_PYMT_AMT

LONG NAME: TRNSTNL_DRUG_ADD_ON_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field is new in 2018 and applies only to hospital outpatient claims.

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