Chronic Condition Warehouse

CODEBOOK:
Medicare Fee For Service (FFS) Claims (for Version L)

FEBRUARY 2021 | VERSION 1.7

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Revision Log

Date	Changed by	Revisions	Version
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
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

Date	Changed by	Revisions	Version
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.

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. 4/1/2003)

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. 4/1/2003 — 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 = 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 = 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)

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 (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)

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

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

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BENE_ID

LABEL: Encrypted CCW Beneficiary ID

DESCRIPTION: The unique CCW identifier for a beneficiary.

The CCW assigns a unique beneficiary identification number to each individual who receives Medicare and/or Medicaid and uses that number to identify an individual's records in all CCW data files (e.g., Medicare claims, MAX claims, 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 = California
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
67 = Texas
68 = Florida (eff. 10/2005)
69 = Florida (eff. 10/2005)
70 = Kansas (eff. 10/2005)
71 = Louisiana (eff. 10/2005)
72 = Ohio (eff. 10/2005)
73 = Pennsylvania (eff. 10/2005)
74 = Texas (eff. 10/2005)
80 = Maryland (eff. 8/2000)
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa; otherwise unknown

COMMENT: —

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BENE_TOT_COINSRNC_DAYS_CNT

LABEL: Beneficiary Total Coinsurance Days Count

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

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

Different rules apply for lifetime reserve days, etc.

SHORT NAME: COIN_DAY

LONG NAME: BENE_TOT_COINSRNC_DAYS_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: —

COMMENT: —

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BETOS_CD

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

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

This field is included 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:

M1A = Office visits — new
M1B = Office visits — established
M2A = Hospital visit — initial
M2B = Hospital visit — subsequent
M2C = Hospital visit — critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist — pathology
M5B = Specialist — psychiatry
M5C = Specialist — ophthalmology
M5D = Specialist — other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure — breast
P1B = Major procedure — colectomy
P1C = Major procedure — cholecystectomy
P1D = Major procedure — turp
P1E = Major procedure — hysterectomy
P1F = Major procedure — explor/decompr/excisdisc
P1G = Major procedure — Other
P2A = Major procedure, cardiovascular—CABG
P2B = Major procedure, cardiovascular—Aneurysm repair
P2C = Major Procedure, cardiovascular — Thromboendarterectomy
P2D = Major procedure, cardiovascular — Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular — Pacemaker insertion
P2F = Major procedure, cardiovascular — Other
P3A = Major procedure, orthopedic — Hip fracture repair
P3B = Major procedure, orthopedic — Hip replacement
P3C = Major procedure, orthopedic — Knee replacement
P3D = Major procedure, orthopedic — other
P4A = Eye procedure — corneal transplant
P4B = Eye procedure — cataract removal/lens insertion
P4C = Eye procedure — retinal detachment
P4D = Eye procedure — treatment of retinal lesions
P4E = Eye procedure — other
P5A = Ambulatory procedures — skin
P5B = Ambulatory procedures — musculoskeletal

P5C = Ambulatory procedures — inguinal hernia repair
P5D = Ambulatory procedures — lithotripsy
P5E = Ambulatory procedures — other
P6A = Minor procedures — skin
P6B = Minor procedures — musculoskeletal
P6C = Minor procedures — other (Medicare fee schedule)
P6D = Minor procedures — other (non-Medicare fee schedule)
P7A = Oncology — radiation therapy
P7B = Oncology — other
P8A = Endoscopy — arthroscopy
P8B = Endoscopy — upper gastrointestinal
P8C = Endoscopy — sigmoidoscopy
P8D = Endoscopy — colonoscopy
P8E = Endoscopy — cystoscopy
P8F = Endoscopy — bronchoscopy
P8G = Endoscopy — laparoscopic cholecystectomy
P8H = Endoscopy — laryngoscopy
P8I = Endoscopy — other
P9A = Dialysis services (Medicare fee schedule)
P9B = Dialysis services (non-Medicare fee schedule)
I1A = Standard imaging — chest
I1B = Standard imaging — musculoskeletal
I1C = Standard imaging — breast
I1D = Standard imaging — contrast gastrointestinal
I1E = Standard imaging — nuclear medicine
I1F = Standard imaging — other
I2A = Advanced imaging — CAT/CT/CTA: brain/head/neck
I2B = Advanced imaging — CAT/CT/CTA: other
I2C = Advanced imaging — MRI/MRA: brain/head/neck
I2D = Advanced imaging — MRI/MRA: other
I3A = Echography/ultrasonography — eye
I3B = Echography/ultrasonography — abdomen/pelvis
I3C = Echography/ultrasonography — heart
I3D = Echography/ultrasonography — carotid arteries
I3E = Echography/ultrasonography — prostate, transrectal
I3F = Echography/ultrasonography — other
I4A = Imaging/procedure — heart including cardiac catheterization
I4B = Imaging/procedure — other
T1A = Lab tests — routine venipuncture (non-Medicare fee schedule)
T1B = Lab tests — automated general profiles
T1C = Lab tests — urinalysis
T1D = Lab tests — blood counts
T1E = Lab tests — glucose
T1F = Lab tests — bacterial cultures
T1G = Lab tests — other (Medicare fee schedule)
T1H = Lab tests — other (non-Medicare fee schedule)
T2A = Other tests — electrocardiograms
T2B = Other tests — cardiovascular stress tests
T2C = Other tests — EKG monitoring
T2D = Other tests — other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Prosthetic/Orthotic devices
D1G = Drugs Administered through DME
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Hearing and speech services
O1G = Immunizations/Vaccinations
Y1 = Other — Medicare fee schedule

Y2 = Other — non-Medicare fee schedule

Z1 = Local codes
Z2 = Undefined codes

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

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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: —

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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: —

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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. 7/3/2000)

K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/2000)

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) Datamatch (converted to '14' 2-byte code)

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

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

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

+ = MSP cost avoided — Pharmacy Benefit Manager Data Sharing

Agreement (eff. 4/2006) (converted to '18' 2-byte code)

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

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

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

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

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

On 4/1/2002, 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.

^ Back to TOC ^

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; effective May 1, 2007), which replaces legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

^ Back to TOC ^

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.

^ Back to TOC ^

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.

^ Back to TOC ^

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: —

^ Back to TOC ^

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: —

^ Back to TOC ^

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.

^ Back to TOC ^

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.

^ Back to TOC ^

CARR_LINE_PRCNG_LCLTY_CD

LABEL: Carrier Line Pricing Locality Code

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

SHORT NAME: LCLTY_CD

LONG NAME: CARR_LINE_PRCNG_LCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: Medicare Localities

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

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

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

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

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

^ Back to TOC ^

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.

^ Back to TOC ^

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: —

^ Back to TOC ^

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.

^ Back to TOC ^

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. 08/19/2012) (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 — Healthnow (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) — Healthnow (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)

01380 = Oregon — AETNA (eff. 1983; term. 09/2000)

01390 = Washington — AETNA (eff. 1994; term. 09/2000)

02050 = California — TOLIC (eff. 1983; term. 09/1991)

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

05130 = Idaho — CIGNA (eff. 1983)

05330 = NEW YORK — Equitable

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)

06140 = ILLINOIS — CONTINENTAL CASUALTY (term. 11/2008)

07180 = Kentucky — Metropolitan (term. 11/2000)

08190 = Louisiana — Pan American10070 = RRB — UnitedHealthcare (term. 02/2004)

10071 = RRB — United Healthcare (term. 2000)

10074 = RRB — United Healthcare (term. 09/2000)

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)

10490 = Virginia — Metra Health (eff. 1983; term. 05/1997)

10555 = DMERC A — United Healthcare (eff. 1993; term. 12/1993)

14330 = New York — GHI (eff. 1983; term. 07/2008) (replaced by MAC #13292)

16360 = Ohio — Nationwide Insurance Co. (eff. 1983; term. 2002)

16510 = West Virginia — Nationwide Insurance Co. (eff. 1983; term. 2002)

31140 = N. California — National Heritage Ins. (eff. 1997; term. 08/2008) (replaced by MAC #01102)

31142 = Maine — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced with MAC # 14102)

31143 = Massachusetts — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced with MAC # 14202)

31144 = New Hampshire — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced with MAC # 14302)

31145 = Vermont — National Heritage Ins. (eff. 1998; term. 05/2009)

31146 = So. California — NHIC (eff. 2000; term. 08/2008)

80884 = Contractor ID for Physician Risk Adjustment Data (data not sent through NCH, but through Palmetto)

Medicare Administrative Contractors (MACs)

JURISDICTION 1 — Part B MACs

01002 = J1 Roll-up

01102 = California (eff. 9/1/08) (replaces carrier #00832)

01192 = Palmetto GBA J1 (S CA) (eff. 09/2001/2008)

01202 = Hawaii (eff. 8/1/08) (replaces carrier #00833)

01302 = Nevada (eff. 8/1/08) (replaces carrier #00834)

02002 = JF Roll-up (2/3)

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)

JURISDICTION 3 — Part B MACs

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)

JURISDICTION 4 — Part B MACs

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)

JURISDICTION 5 — Part B MACs

05002 = J5 Roll-up

05102 = Iowa (eff.2/1/08) (replaces carrier #00826)

05202 = Kansas (eff. 3/1/08) (replaces carrier #00650)

05302 = W. Missouri (eff. 3/1/08) (replaces carrier #00651 or 00740)

05392 = E. Missouri (eff. 6/1/08) (replaces carrier #00523)

05402 = Nebraska (eff. 3/1/08) (replaces carrier #00655)

06002 = J6 Roll-up

06102 = Illinois

06202 = Minnesota

06302 = Wisconsin

07002 = JH Roll-up (4/7)

07102 = Arkansas — Novitas Solutions JH (eff. 08/11/2012) (CR7812)

07202 = Louisiana — Novitas Solutions JH (eff. 08/11/2012)

07302 = Mississippi — Novitas Solutions JH (eff. 10/20/2012)

JURISDICTION 8 — Part B MACs

08002 = J8 Roll-up

08102 = Indiana (eff. 8/20/2012) (replaces carrier #00630)

08202 = Michigan (eff. 7/16/2012) (replaces carrier #00953)

JURISDICTION 9 — Part B MACs

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)

JURISDICTION 10 — Part B MACs

10002 = J10 Roll-up

10102 = Alabama (eff. 5/4/09) (replaces carrier #00510)

10202 = Georgia (eff. 8/3/09) (replaces carrier #00511)

10302 = Tennessee (eff. 9/1/09) (replaces carrier #05440)

JURISDICTION 11 — Part B MACs

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)

JURISDICTION 12 — Part B MACs

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)

JURISDICTION 13 — Part B MACs

13002 = J13 Roll-up

13102 = Connecticut (eff. 8/1/2008) (replaces carrier #00591)

13202 = E. New York (eff. 7/18/2008) (replaces carrier #00803)

13282 = W. New York (eff. 9/1/2008) (replaces carrier #00801)

13292 = New York (Queens) (eff. 7/18/2008) (replaces carrier #14330)

JURISDICTION 14 — Part B MACs

14002 = J14 Roll-up

14102 = Maine (eff. 6/1/2009) (replaces carrier #31142)

14202 = Massachusetts (eff. 6/1/2009) (replaces carrier #31143)

14302 = N. Hampshire (eff. 6/1/2009) (replaces carrier #31144)

14402 = Rhode Island (eff. 5/1/2009) (replaces carrier #00524)

14502 = Vermont (eff. 6/1/2009) (replaces carrier #31145)

15002 = J15 Roll-up

15102 = Kentucky (eff. 4/30/2011) CGS Government Services

15202 = Ohio (eff. 06/15/2011) CGS Government Services

Durable Medical Equipment (DME) MACs

16003 = National Heritage Insurance Company (NHIC) (A) (eff. 7/1/2006) (replaces carrier #00811)

17003 = Administar Federal, Inc. (B) (eff. 7/1/2006) (replaces carrier #00635)

18003 = Connecticut General (CIGNA) (C) (eff. 06/2006) (replaces carrier #00885)

19003 = Noridian Mutual Ins. Co (D) (eff. 10/1/2006) (replaces carrier #05655)

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.

^ Back to TOC ^

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; effective May 1, 2007), which replaces legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

^ Back to TOC ^

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: —

^ Back to TOC ^

CLM_ADMSN_DT

LABEL: Claim Admission Date

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

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

SHORT NAME: ADMSN_DT

LONG NAME: CLM_ADMSN_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

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

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

^ Back to TOC ^

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.

^ Back to TOC ^

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.

^ Back to TOC ^

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.

^ Back to TOC ^

CLM_CLNCL_TRIL_NUM

LABEL: Clinical Trial Number

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

SHORT NAME: CCLTRNUM

LONG NAME: CLM_CLNCL_TRIL_NUM

TYPE: CHAR

LENGTH: 8

SOURCE: NCH

VALUES: —

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

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

^ Back to TOC ^

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: —

^ Back to TOC ^

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 3 characters to 4.

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 ^

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: —

^ Back to TOC ^

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.

^ Back to TOC ^

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).

^ Back to TOC ^

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

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 (a.k.a. 'Statement Covers From Date').

SHORT NAME: FROM_DT

LONG NAME: CLM_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

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

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

For Part B Non-institutional (Carrier and DME) services, this variable corresponds with the earliest of any of the line-item level dates (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.

^ Back to TOC ^

CLM_FULL_STD_PYMT_AMT

LABEL: Claim Full Standard Payment Amount

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

This amount does not include any applicable outlier payment amount.

SHORT NAME: CLM_FULL_STD_PYMT_AMT

LONG NAME: CLM_FULL_STD_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

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

^ Back to TOC ^

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 by which the patient was admitted is not known.

A = Transfer from a Critical Access Hospital — patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

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

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

^ Back to TOC ^

CLM_HHA_TOT_VISIT_CNT

LABEL: Claim HHA Total Visit Count

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

SHORT NAME: VISITCNT

LONG NAME: CLM_HHA_TOT_VISIT_CNT

TYPE: NUM

LENGTH: 3

SOURCE: NCH

VALUES: —

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

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

^ Back to TOC ^

CLM_HOSPC_START_DT_ID

LABEL: Claim Hospice Start Date

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

SHORT NAME: HSPCSTRT

LONG NAME: CLM_HOSPC_START_DT_ID

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

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 4th 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.

^ Back to TOC ^

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

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

^ Back to TOC ^

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

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

^ Back to TOC ^

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.

^ Back to TOC ^

CLM_IP_ADMSN_TYPE_CD

LABEL: Claim Inpatient Admission Type Code

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

SHORT NAME: TYPE_ADM

LONG NAME: CLM_IP_ADMSN_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = Unknown Value (but present in data)

1 = Emergency — The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.

2 = Urgent — The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.

3 = Elective — The patient's condition permitted adequate time to schedule the availability of suitable accommodations.

4 = Newborn — Necessitates the use of special source of admission codes.

5 = Trauma Center — visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

6 = Reserved

7 = Reserved

8 = Reserved

9 = Unknown — Information not available.

COMMENT: —

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CLM_IP_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.

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CLM_IP_LOW_VOL_PMT_AMT

LABEL: Claim Inpatient Low Volume Payment Amount

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

SHORT NAME: CLM_IP_LOW_VOL_PMT_AMT

LONG NAME: CLM_IP_LOW_VOL_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Payment adjustment for low income IPPS hospitals.

This field was new in 2011.

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CLM_LINE_NUM

LABEL: Claim Line Number

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

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

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

SHORT NAME: CLM_LN

LONG NAME: CLM_LINE_NUM

TYPE: NUM

LENGTH: 13

SOURCE: CCW

VALUES: —

COMMENT: —

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CLM_MCO_PD_SW

LABEL: Claim MCO Paid Switch

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

SHORT NAME: MCOPDSW

LONG NAME: CLM_MCO_PD_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

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CLM_MDCL_REC

LABEL: Claim Medical Record Number

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

SHORT NAME: CLM_MDCL_REC

LONG NAME: CLM_MDCL_REC

TYPE: CHAR

LENGTH: 17

SOURCE: NCH

VALUES: —

COMMENT: This variable may be null/missing.

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CLM_MDCR_NON_PMT_RSN_CD

LABEL: Claim Medicare Non-Payment Reason Code

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

SHORT NAME: NOPAY_CD

LONG NAME: CLM_MDCR_NON_PMT_RSN_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

A = Covered worker's compensation (Obsolete)

B = Benefit exhausted

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

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

E = MSP cost avoided — IRS/SSA/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 4/1/2002. Prior to 4/1/2002, data only came in Inpatient/SNF claims.

Effective 4/1/2002, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. Reference table of code for the crosswalk.

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

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

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CLM_MODEL_4_READMSN_IND_CD

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).

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

COMMENT: There are five of these ACO fields (CLM_NEXT_GNRTN_ACO_IND_CD1–CLM_NEXT_GNRTN_ACO_IND_CD5).

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CLM_NON_UTLZTN_DAYS_CNT

LABEL: Claim Medicare Non-Utilization Days Count

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

SHORT NAME: NUTILDAY

LONG NAME: CLM_NON_UTLZTN_DAYS_CNT

TYPE: NUM

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_OP_BENE_PMT_AMT

LABEL: Claim Outpatient Payment Amount to Beneficiary

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

SHORT NAME: BENEPMT

LONG NAME: CLM_OP_BENE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CLM_OP_ESRD_MTHD_CD

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

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

SHORT NAME: CLM_OP_ESRD_MTHD_CD

LONG NAME: CLM_OP_ESRD_MTHD_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

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CLM_OP_PRVDR_PMT_AMT

LABEL: Claim Outpatient Provider Payment Amount

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

SHORT NAME: PRVDRPMT

LONG NAME: CLM_OP_PRVDR_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CLM_OP_TRANS_TYPE_CD

LABEL: Claim Outpatient transaction type

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

SHORT NAME: CLM_OP_TRANS_TYPE_CD

LONG NAME: CLM_OP_TRANS_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

A = Outpatient Psychiatric Hospital
B = Outpatient tuberculosis (TB) Hospital
C = Outpatient General Care Hospital
D = Outpatient Skilled Nursing Facility (SNF)
E = Home Health Agency
F = Comprehensive Health Care
G = Clinical Rehab Agency
H = Rural Health Clinic
I = Satellite Dialysis Facility
J = Limited Care Facility
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: http://www.medpac.gov/payment_basics.cfm and also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" Reference the list of MLN publications at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html

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CLM_PMT_AMT

LABEL: Claim (Medicare) Payment Amount

DESCRIPTION: The Medicare claim payment amount.

For hospital services, this amount does not include the claim pass-through per diem payments made by Medicare. To obtain the total amount paid by Medicare for the claim, the pass-through amount (which is the daily per diem amount) must be multiplied by the number of Medicare-covered days (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: http://www.medpac.gov/payment_basics.cfm).

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.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: http://www.medpac.gov/payment_basics.cfm)

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

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CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT

LABEL: Claim PPS Capital Disproportionate Share Amount

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

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

SHORT NAME: DISP_SHR

LONG NAME: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: http://www.medpac.gov/payment_basics.cfm).

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

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CLM_PPS_CPTL_EXCPTN_AMT

LABEL: Claim PPS Capital Exception Amount

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

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

SHORT NAME: CPTL_EXP

LONG NAME: CLM_PPS_CPTL_EXCPTN_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: http://www.medpac.gov/payment_basics.cfm)

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

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CLM_PPS_CPTL_FSP_AMT

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

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

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

SHORT NAME: CPTL_FSP

LONG NAME: CLM_PPS_CPTL_FSP_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: http://www.medpac.gov/payment_basics.cfm)

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

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CLM_PPS_CPTL_IME_AMT

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

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

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

SHORT NAME: IME_AMT

LONG NAME: CLM_PPS_CPTL_IME_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: http://www.medpac.gov/payment_basics.cfm).

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

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CLM_PPS_CPTL_OUTLIER_AMT

LABEL: Claim PPS Capital Outlier Amount

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

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

SHORT NAME: CPTLOUTL

LONG NAME: CLM_PPS_CPTL_OUTLIER_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: http://www.medpac.gov/payment_basics.cfm)

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

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CLM_PPS_IND_CD

LABEL: Claim PPS Indicator Code

DESCRIPTION: The code indicating whether or not:

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

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

SHORT NAME: PPS_IND

LONG NAME: CLM_PPS_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

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CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT

LABEL: Claim PPS Old Capital Hold Harmless Amount

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

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

SHORT NAME: HLDHRMLS

LONG NAME: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

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

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

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

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CLM_PRCR_RTRN_CD

LABEL: Claim Pricer Return Code

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

SHORT NAME: CLM_PRCR_RTRN_CD

LONG NAME: CLM_PRCR_RTRN_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

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

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

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

Inpatient Hospital Payment return codes:

00 = Paid normal DRG payment

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

02 = Paid as a cost outlier

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

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

06 = Provider refused cost outlier

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

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

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

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

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

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.

26 = For Long Term Care PPS, it means short stay payment based on IPPS-comparable threshold without outlier.

LTCH Error return codes:

50 = Provider specific rate not numeric

51 = Provider record terminated

52 = Invalid wage index

53 = Waiver state — not calculated by PPS

54 = DRG on claim not found in table

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

56 = Invalid length of stay

57 = Provider specific rate zero when blended payment requested

58 = Total covered charges not numeric

59 = Provider specific record not found

60 = MSA wage index record not found

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

62 = Invalid number of covered days

65 = Operating cost-to-charge ratio not numeric

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

72 = Invalid blend indicator (not 1 thru 5)

73 = Discharged before provider FY begin date

74 = Provider FY begin date not in 2002

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

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

SNF Payment return codes:

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

20 = Bad RUG code

30 = Bad MSA code

40 = Thru date < July 1, 1998 or invalid

50 = Invalid Federal blend for that year

60 = Invalid Federal blend

61 = Federal blend = 0 and SNF thru date < January 1, 2000

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

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

Hospice Payment Return Codes:

00 = Home rate returned Hospice Error Return Codes:

10 = Bad units

20 = Bad units2 < 8

30 = Bad MSA code

40 = Bad hospice wage index from MSA file

50 = Bad bene wage index from MSA file

51 = Bad provider number

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

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

Home Health Payment Return Codes:

00 = Final payment where no outlier applies

01 = Final payment where outlier applies

03 = Initial percentage payment, 0%

04 = Initial percentage payment, 50%

05 = Initial percentage payment, 60%

06 = LUPA payment only

07 = Final payment, SCIC

08 = Final payment, SCIC with outlier

09 = Final payment, PEP

11 = Final payment, PEP with outlier

12 = Final payment, SCIC within PEP

13 = Final payment, SCIS within PEP with outlier

Home Health Error Return Codes:

10 = Invalid TOB

15 = Invalid PEP Days

16 = Invalid HRG Days, >60

20 = PEP indicator invalid

25 = Med review indicator invalid

30 = Invalid MSA code

35 = Invalid Initial Payment Indicator

40 = Dates < October 1, 2000 or invalid

70 = Invalid HRG Code

75 = No HRG present in 1st occurrence

80 = Invalid Revenue code

85 = No revenue code present on HH final claim/adjustment

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

Outpatient PPS Payment return codes:

01 = Line processed to payment

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

22 = For Outpatient PPS, it means daily coinsurance limitation.

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

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

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_RLT_COND_CD

LABEL: Claim Related Condition Code

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

SHORT NAME: RLT_COND

LONG NAME: CLM_RLT_COND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

01 THRU 16 = Insurance related

17 THRU 30 = Special condition

31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old

36 THRU 45 = Accommodation

46 THRU 54 = CHAMPUS information

55 THRU 59 = Skilled nursing facility

60 THRU 70 = Prospective payment

71 THRU 99 = Renal dialysis setting

A0 THRU B9 = Special program codes

C0 THRU C9 = QIO approval services

D0 THRU W0 = Change conditions

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01 = Military service related — Medical condition incurred during military service.

02 = Employment related — Patient alleged that the medical condition causing this episode of care was due to environment/events resulting from employment.

03 = Patient covered by insurance not reflected here — Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.

04 = Health Maintenance Organization (HMO) enrollee — Medicare beneficiary is enrolled in an HMO. Hospital must also expect to receive payment from HMO.

05 = Lien has been filed — Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.

06 = ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.

07 = Treatment of nonterminal condition for hospice patient —

The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.

08 = Beneficiary would not provide information concerning other insurance coverage.

09 = Neither patient nor spouse is employed — Code indicates that in response to development questions, the patient and spouse have denied employment.

10 = Patient and/or spouse is employed but no EGHP coverage exists or other employer sponsored/provided health insurance covering patient.

11 = The disabled beneficiary and/or family member has no group coverage from a LGHP or other employer sponsored/provided health insurance covering patient.

12 = Payer code — Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.

13 = Payer code — Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.

14 = Payer code — Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.

15 = Clean claim. Delayed in CMS's processing system.

16 = SNF transition exemption — An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.

17 = Patient is homeless.

18 = Maiden name retained — A dependent spouse entitled to benefits who does not use her husband's last name.

19 = Child retains mother's name — A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.

20 = Beneficiary requested billing — Provider realizes the services on this bill are at a non-covered level of care or otherwise excluded from coverage, but the bene has requested formal determination.

21 = Billing for denial notice — The SNF or HHA realizes services are at a non-covered level of care or excluded but requests a Medicare denial in order to bill Medicaid or other insurer.

22 = Patient on multiple drug regimen — A patient who is receiving multiple intravenous drugs while on home IV therapy

23 = Home caregiver available — The patient has a caregiver available to assist him or her during self-administration of an intravenous drug

24 = Home IV patient also receiving HHA services — the patient is under care of HHA while receiving home IV drug therapy services

25 = Reserved for national assignment

26 = VA eligible patient chooses to receive services in Medicare

certified facility rather than a VA facility

27 = Patient referred to a sole community hospital for a diagnostic laboratory test — (sole community hospital only).

28 = Patient and/or spouse's EGHP is secondary to Medicare — Qualifying EGHP for employers who have fewer than 20 employees.

29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare — Qualifying LGHP for employer having fewer than 100 full and part-time employees

30 = Qualifying Clinical Trials — Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.

31 = Patient is student (full time — day) — Patient declares that he or she is enrolled as a full-time day student.

32 = Patient is student (cooperative/work study program)

33 = Patient is student (full time-night) — Patient declares that he or she is enrolled as a full-time night student.

34 = Patient is student (part time) — Patient declares that he or she is enrolled as a part time student.

36 = General care patient in a special unit — Patient is temporarily placed in special care unit bed because no general care beds were available.

37 = Ward accommodation at patient's request — Patient is assigned to ward accommodations at patient's request.

38 = Semi-private room not available — Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.

39 = Private room medically necessary — Patient needed a private room for medical reasons.

40 = Same day transfer — Patient transferred to another facility before midnight of the day of admission.

41 = Partial hospitalization services. For OP services, this includes a variety of psychiatric programs.

42 = Continuing Care Not Related to Inpatient Admission — continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services. (eff. 10/2001)

43 = Continuing Care Not Provided Within Prescribed Post-Discharge Window — continuing care was related to the inpatient admission, but the prescribed care was not provided within the post-discharge window. (eff. 10/2001)

44 = Inpatient Admission Changed to Outpatient — For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not

meet its inpatient criteria. (eff. 4/1/2004)

45 = Reserved for national assignment.

46 = Non-availability statement on file for TRICARE claim for nonemergency IP care for TRICARE bene residing within the catchment area (usually a 40-mile radius) of a uniform services hospital.

47 = Reserved for TRICARE.

48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs). Claims submitted by TRICARE.

49 = Product Replacement within Product Lifecycle — replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)

50 = Product Replacement for Known Recall of a Product — Manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006)

51 = Reserved for national assignment.

52 = Reserved for national assignment.

53 = Reserved for national assignment.

54 = No skilled HH visits in billing period (eff. 7/2016)

55 = SNF bed not available — The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.

56 = Medical appropriateness — Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period

57 = SNF readmission — Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.

58 = Terminated Managed Care Organization Enrollee — patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.

59 = Non-primary ESRD Facility — ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. (eff.10/2004)

60 = Operating cost day outlier — PRICER indicates this bill is length of stay outlier (PPS)

61 = Operating cost outlier — PRICER indicates this bill is a cost outlier (PPS)

62 = PIP bill — This bill is a periodic interim payment bill.

63 = Payer Only Code — Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or patient in State or local custody meeting requirements of 42 CFR 411.4(b)

64 = Other than clean claim — The claim is not a 'clean claim'

65 = Non-PPS bill — The bill is not a prospective payment system bill.

66 = Hospital Does Not Wish Cost Outlier Payment — Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)

67 = Beneficiary elects not to use Lifetime Reserve (LTR) days

68 = Beneficiary elects to use LTR days

69 = IME/DGME/NandA Payment Only — providers request for request for a supplemental payment for IME/DGME/NandAH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health).

70 = Self-administered Epoetin (EPO) — Billing is for a home dialysis patient who self-administers EPO.

71 = Full care in unit — Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.

72 = Self-care in unit — Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.

73 = Self-care training — Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.

74 = Home — Billing is for a patient who received dialysis services at home.

75 = Home dialysis patient using a dialysis machine that was purchased under the 100% program.

76 = Back-up in facility dialysis — Billing is for a patient who received dialysis services in a back-up facility.

77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by the primary payer as payment in full — no Medicare payment is due.

78 = New coverage not implemented by HMO, indicates newly covered service under Medicare for which HMO does not pay.

79 = CORF services provided off site — Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

80 = Home Dialysis — Nursing Facility — Home dialysis furnished in a SNF or nursing facility. (eff. 4/4/2005)

81–84 = Reserved for state assignment.

85 = Delayed Recertification of Hospice Terminal Illness (eff. 1/2017)

86–99 = Reserved for state assignment.

A0 = Special Zip Code Reporting — five-digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/2001)

A1 = EPSDT/CHAP — Early and periodic screening diagnosis and treatment special program indicator code.

A2 = Physically handicapped children's program — Services provided receive special funding through Title 8 of the Social Security Act or

the CHAMPUS program for the handicapped.

A3 = Special federal funding — Designed for uniform use by state uniform billing committees. Special program indicator code

A4 = Family planning — Designed for uniform use by state uniform billing committees. Special program indicator code

A5 = Disability — Designed for uniform use by state uniform billing committees.

A6 = PPV/Medicare — Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.

A7 = Induced abortion to avoid danger to woman's life.

A8 = Induced abortion — Victim of rape/incest. Special program indicator code

A9 = Second opinion surgery — Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.

AA = Abortion Performed due to Rape (eff. 10/1/2002)

AB = Abortion Performed due to Incest (eff. 10/1/2002)

AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality (eff. 10/1/2002)

AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from, or exacerbated by the Pregnancy itself (eff. 10/1/2002)

AE = Abortion Performed due to physical health of mother that is not life endangering (eff. 10/1/2002)

AF = Abortion performed due to emotional/psychological health of mother (eff. 10/1/2002)

AG = Abortion performed due to social economic reasons (eff. 10/1/2002)

AH = Elective Abortion (eff. 10/1/2002)

AI = Sterilization (eff. 10/1/2002)

AJ = Payer Responsible for copayment (4/1/2003)

AK = Air Ambulance Required — For ambulance claims. Time needed to transport poses a threat. (eff. 10/16/2003)

AL = Specialized Treatment/bed Unavailable — For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility. (eff. 10/16/2003)

AM = Non-emergency Medically Necessary Stretcher Transport Required — For ambulance claims. Non-emergency medically necessary stretcher transport required. (eff. 10/16/2003)

AN = Preadmission Screening Not Required — person meets the criteria for an exemption from preadmission screening. (eff. 1/1/2004)

B0 = Medicare Coordinated Care Demonstration Program — patient is a participant in a

Medicare Coordinated Care Demonstration (eff. 10/2001)

B1 = Beneficiary ineligible for demonstration program (eff. 1/2002)

B2 = Critical Access Hospital Ambulance Attestation — Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule

B3 = Pregnancy Indicator — Indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/2003)

B4 = Admission Unrelated to Discharge — Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.

B5 = Special program indicator Reserved for national assignment.

B6 = Special program indicator Reserved for national assignment.

B7 = Special program indicator Reserved for national assignment.

B8 = Special program indicator Reserved for national assignment.

B9 = Special program indicator Reserved for national assignment.

C0 = Reserved for national assignment.

C1 = Approved as billed — Claim has been reviewed by the QIO and has been fully approved including any outlier.

C2 = QIO approval indicator services. **NOTE:** Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C3 = Partial approval — some portion (days or services). From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code "77" in FL 36 or code "46" in FL 39–41).

C4 = Admission denied — The patient's need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary.

C5 = Post-payment review applicable — Any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.

C6 = Preadmission/Pre-procedure authorization — The QIO authorized this admission/procedure but has not reviewed the services provided.

C7 = Extended authorization — The QIO has authorized these services for an extended length of time but has not reviewed the services provided.

C8 = Reserved for national assignment. QIO approval indicator services

C9 = Reserved for national assignment. QIO approval indicator services

D0 = Changes to service dates.

D1 = Changes in charges.

D2 = Changes in revenue codes/HCPCS/HIPPS Rate Code — Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)

D3 = Second or subsequent interim PPS bill.

D4 = Change in ICD-9-CM diagnosis and/or procedure code

D5 = Cancel only to correct a beneficiary claim account number (HICN) or provider identification number.

D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill).

D7 = Change to make Medicare the secondary payer.

D8 = Change to make Medicare the primary payer.

D9 = Any other change.

DR = Disaster Relief (eff. 10/2005) — Code used to facilitate claims processing and track services/items provided to victims of disasters.

E0 = Change in patient status.

EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study

G0 = Distinct Medical Visit — Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits.

H0 = Delayed Filing, Statement of Intent Submitted — statement of intent was submitted within the qualifying period to specifically identify the existence of another third-party liability situation.

M0 = All-inclusive rate for outpatient services. Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 = Roster billed influenza virus vaccine or pneumococcal pneumonia vaccine (PPV).

M2 = HHA Payment Significantly Exceeds Total Charges — Used when payment to an HHA is significantly in excess of covered billed charges.

MA =GI Bleed.

MB = Pneumonia.

MC = Pericarditis.

MD =Myelodysplastic Syndrome.

ME = Hereditary Hemolytic and Sickle Cell Anemia.

MF =Monoclonal Gammopathy.

W0 = United Mine Workers of America (UMWA) SNF demonstration indicator

XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/2007)

COMMENT: —

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CLM_RLT_OCRNC_CD

LABEL: Claim Related Occurrence Code

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

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

SHORT NAME: OCRNC_CD

LONG NAME: CLM_RLT_OCRNC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

01 THRU 09 = Accident

10 THRU 19 = Medical condition

20 THRU 39 = Insurance related

40 THRU 69 = Service related

A1–A3= Miscellaneous

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01 = Auto accident — The date of an auto accident.

02 = No-fault insurance involved, including auto accident/other — The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).

03 = Accident/tort liability — The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.

04 = Accident/employment related — The date of an accident relating to the patient's employment.

05 = Other accident — The date of an accident not described by the codes 01 thru 04.

06 = Crime victim — Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

07 = Reserved for national assignment.

08 = Reserved for national assignment.

11 = Onset of symptoms/illness — The date the patient first became aware of symptoms/illness.

12 = Date of onset for a chronically dependent individual — Code indicates the date the patient/bene became a chronically dependent individual.

13 = Reserved for national assignment.

14 = Reserved for national assignment.

15 = Reserved for national assignment.

16 = Reserved for national assignment.

17 = Date outpatient occupational therapy plan established or last reviewed — Code indicating the date an occupational therapy plan was established or last reviewed.

18 = Date of retirement (patient/bene) — Code indicates the date of retirement for the patient/bene.

19 = Date of retirement spouse — Code indicates the date of retirement for the patient's spouse.

20 = Guarantee of payment began — The date on which the provider began claiming Medicare payment under the guarantee of payment provision.

21 = UR notice received — Code indicating the date of receipt by the hospital and SNF of the UR committee's finding that the admission or future stay was not medically necessary.

22 = Active care ended — The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.

23 = Cancellation of Hospice benefits — The date the RHHI cancelled the hospice benefit. (eff. 10/2000). **NOTE:** This will be different than the revocation of the hospice benefit by beneficiaries.

24 = Date insurance denied — The date the insurer's denial of coverage was received by a higher priority payer.

25 = Date benefits terminated by primary payer — The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.

26 = Date skilled nursing facility (SNF) bed available — The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.

27 = Date of Hospice Certification or Re-Certification — code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/2001)

27 = Date home health plan established or last reviewed — Code indicating the date a home health plan of treatment was established or last reviewed. (Obsolete) not used by hospital unless owner of facility

28 = Date comprehensive outpatient rehabilitation plan established or last reviewed — Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed. Not used by hospital unless owner of facility

29 = Date OPT plan established or last reviewed — the date a plan of treatment was established for outpatient physical therapy. Not used by hospital unless owner of facility

30 = Date speech pathology plan treatment established or last reviewed — The date a speech pathology plan of treatment was established or last reviewed. Not used by hospital unless owner of facility

31 = Date bene notified of intent to bill (accommodations) — The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.

32 = Date bene notified of intent to bill (procedures or treatment) — The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.

33 = First day of the Medicare coordination period for ESRD bene — During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.

34 = Date of election of extended care facilities — The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).

35 = Date treatment started for physical therapy — Code indicates the date services were initiated by the billing provider for physical therapy.

36 = Date of discharge for the IP hospital stay when patient received a transplant procedure — Hospital is billing for immunosuppressive drugs.

37 = The date of discharge for the IP hospital stay when patient received a non-covered transplant procedure — Hospital is billing for immunosuppressive drugs.

38 = Date treatment started for home IV therapy — Date the patient was first treated in his home for IV therapy.

39 = Date discharged on a continuous course of IV therapy — Date the patient was discharged from the hospital on a continuous course of IV therapy.

40 = Scheduled date of admission — The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)

41 = Date of First Test for Pre-admission Testing — The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/2001)

42 = Date of discharge/termination of hospice care — for the final bill for hospice care. Date patient revoked hospice election.

43 = Scheduled Date of Canceled Surgery — date which ambulatory

surgery was scheduled. (eff. 9/2001)

44 = Date treatment started for occupational therapy — Code indicates the date services were initiated by the billing provider for occupational therapy.

45 = Date treatment started for speech therapy — Code indicates the date services were initiated by the billing provider for speech therapy.

46 = Date treatment started for cardiac rehabilitation — Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.

47 = Date Cost Outlier Status Begins — code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/2001)

48 = Payer code — Code reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers will not report it.

49 = Payer code — Code reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers will not report it.

50–55 = Reserved for state assignment

56 = Hospice — incorrect date of Hospice notification of election (NOE). This code indicates the date of certification or recertification of the hospice benefit period, which has been corrected (the corrected date appears in the record for occurrence code = 26). (eff. 1/2018)

57–69 = Reserved for state assignment

A1 = Birthdate, Insured A — The birthdate of the individual in whose name the insurance is carried.

A2 = Effective date, Insured A policy — A code indicating the first date insurance is in force.

A3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer A.

B1 = Birthdate, Insured B — The birthdate of the individual in whose name the insurance is carried.

B2 = Effective date, Insured B policy — A code indicating the first date insurance is in force.

B3 = Benefits exhausted — code indicating the last date for which benefits are available and after which no payment can be made to payer B.

C1 = Birthdate, Insured C — The birthdate of the individual in whose name the insurance is carried.

C2 = Effective date, Insured C policy — A code indicating the first date insurance is in force.

C3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer C.

COMMENT: —

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CLM_RLT_OCRNC_DT

LABEL: Claim Related Occurrence Date

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

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

SHORT NAME: OCRNCDT

LONG NAME: CLM_RLT_OCRNC_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_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 04/2018.

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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 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_SITE_NTRL_PYMT_IPPS_AMT

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

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

SHORT NAME: CLM_SITE_NTRL_PYMT_IPPS_AMT

LONG NAME: CLM_SITE_NTRL_PYMT_IPPS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

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

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CLM_SPAN_CD

LABEL: Claim Occurrence Span Code

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

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

SHORT NAME: SPAN_CD

LONG NAME: CLM_SPAN_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

70 = Payer use only, the non-utilization from/thru dates for PPS-inlier stay where bene had exhausted all full/coinsurance days but covered on cost report. SNF qualifying hospital stay from/thru dates

71 = Hospital prior stay dates — the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.

72 = First/last visit — the dates of the first and last visits occurring in this billing period if the dates are different from those in the statement covers period.

73 = Benefit eligibility period — the inclusive dates during which CHAMPUS medical benefits are available to a sponsor's bene as shown on the bene's ID card.

74 = Non-covered level of care — The from/thru dates of a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span code 76, 77, or 79.

75 = The from/thru dates of SNF level of care during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. Not applicable to swing bed cases. PPS hospitals use in day outlier cases only.

76 = Patient liability — From/thru dates of period of non-covered care for which hospital may charge bene. The FI or PRO must have approved such charges in advance. Patient must be notified in writing 3 days prior to non-covered period

77 = Provider liability (utilization charged) — The from/thru dates of period of non-covered care for which the provider is liable. Applies to provider liability where bene is charged with utilization and is liable for deductible/coinsurance

78 = SNF prior stay dates — The from/thru dates of any SNF stay that ended within 60 days of this hospital or SNF admission.

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

80–99 = Reserved for state assignment

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

M1 = Provider Liability-No Utilization — from/thru dates of a period of non-covered care that is denied due to lack of medical necessity or custodial care for which the provider is liable. (eff. 10/2001)

M2 = Dates of Inpatient Respite Care — from/thru dates of a period of inpatient respite care for hospice patients. (eff. 10/2000)

COMMENT: —

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CLM_SPAN_FROM_DT

LABEL: Claim Occurrence Span From Date

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

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

SHORT NAME: SPANFROM

LONG NAME: CLM_SPAN_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_SPAN_THRU_DT

LABEL: Claim Occurrence Span Through Date

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

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

SHORT NAME: SPANTHRU

LONG NAME: CLM_SPAN_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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CLM_SRC_IP_ADMSN_CD

LABEL: Claim Source Inpatient Admission Code

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

SHORT NAME: SRC_ADMS

LONG NAME: CLM_SRC_IP_ADMSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: For Inpatient/SNF Claims:

0 = ANOMALY: invalid value, if present, translate to '9'

1 = Non-Health Care Facility Point of Origin (Physician Referral) — The patient was admitted to this facility upon an order of a physician.

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

3 = HMO referral — Reserved for national Prior to 3/08, HMO referral — The patient was admitted upon the recommendation of a health maintenance organization (HMO) physician.

4 = Transfer from hospital (Different Facility) — The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.

5 = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) — The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

6 = Transfer from another health care facility — The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.

7 = Emergency room — The patient was admitted to this facility after receiving services in this facility's emergency room department (CMS discontinued this code 07/2010, although a small number of claims with this code appear after that time).

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

9 = Information not available — The means by which the patient was admitted is not known.

A = Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital — patient was admitted/referred to this facility as

a transfer from a Critical Access Hospital.

B = Transfer from Another Home Health Agency — The patient was admitted to this home health agency as a transfer from another home health agency. (Discontinued July 1, 2010 — Reference Condition Code 47)

C = Readmission to Same Home Health Agency — The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1, 2010)

D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer — The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

E = Transfer from Ambulatory Surgical Center

F = Transfer from hospice and is under a hospice plan of care or enrolled in hospice program

For Newborn Type of Admission

1 = Normal delivery — A baby delivered without complications.

2 = Premature delivery — A baby delivered with time and/or weight factors qualifying it for premature status.

3 = Sick baby — A baby delivered with medical complications, other than those relating to premature status.

4 = Extramural birth — A baby delivered in a nonsterile environment.

5 = Reserved for national assignment.

6 = Reserved for national assignment.

7 = Reserved for national assignment.

8 = Reserved for national assignment.

9 = Information not available.

COMMENT: —

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CLM_SRVC_CLSFCTN_TYPE_CD

LABEL: Claim Service Classification Type Code

DESCRIPTION: The type of service provided to the beneficiary.

SHORT NAME: TYPESRVC

LONG NAME: CLM_SRVC_CLSFCTN_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

1 = Inpatient

2 = Inpatient or Home Health (covered on Part B)

3 = Outpatient (or HHA — covered on Part A)

4 = Other (Part B) — (Includes HHA medical and other health services, e.g., SNF osteoporosis injectable drugs)

5 = Intermediate care — level I

6 = Intermediate care — level II

7 = Subacute Inpatient (revenue code 019X required) (formerly Intermediate care — level III)

8 = Swing bed

For facility type code 7 (clinics):

1 = Rural Health Clinic (RHC)

2 = Hospital based or independent renal dialysis facility

3 = Free-standing provider based federally qualified health center (FQHC)

4 = Other Rehabilitation Facility (ORF)

5 = Comprehensive Rehabilitation Center (CORF)

6 = Community Mental Health Center (CMHC)

7 = Federally Qualified Health Center (FQHC)

For facility type code 8 (special facility):

1 = Hospice (non-hospital based)

2 = Hospice (hospital based)

3 = Ambulatory surgical center (ASC) in hospital outpatient department

4 = Freestanding birthing center

5 = Critical Access Hospital — Outpatient Services

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

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CLM_SRVC_FAC_ZIP_CD

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

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

SHORT NAME: CLM_SRVC_FAC_ZIP_CD

LONG NAME: CLM_SRVC_FAC_ZIP_CD

TYPE: CHAR

LENGTH: 9

SOURCE: NCH

VALUES: XXXXXXXXX

COMMENT: —

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CLM_SS_OUTLIER_STD_PYMT_AMT

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

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

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

SHORT NAME: CLM_SS_OUTLIER_STD_PYMT_AMT

LONG NAME: CLM_SS_OUTLIER_STD_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

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

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CLM_THRU_DT

LABEL: Claim Through Date

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

SHORT NAME: THRU_DT

LONG NAME: CLM_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

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

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

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

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CLM_TOT_CHRG_AMT

LABEL: Claim Total Charge Amount

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

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

SHORT NAME: TOT_CHRG

LONG NAME: CLM_TOT_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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CLM_TOT_PPS_CPTL_AMT

LABEL: Claim Total PPS Capital Amount

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

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

SHORT NAME: PPS_CPTL

LONG NAME: CLM_TOT_PPS_CPTL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: http://www.medpac.gov/payment_basics.cfm).

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

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CLM_TRTMT_AUTHRZTN_NUM

LABEL: Claim Treatment Authorization Number

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

SHORT NAME: CLM_TRTMT_AUTHRZTN_NUM

LONG NAME: CLM_TRTMT_AUTHRZTN_NUM

TYPE: CHAR

LENGTH: 18

SOURCE: NCH

VALUES: 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:

01 = Most Common Semi-Private Rate — to provide for the recording of hospital's most common semi-private rate.

02 = Hospital Has No Semi-Private Rooms — Entering this code requires $0.00 amount.

03 = Reserved for national assignment.

04 = Inpatient professional component charges which are combined billed — For use only by some all-inclusive rate hospitals.

05 = Professional component included in charges and also billed separately to carrier — For use on Medicare and Medicaid bills if the state requests this information.

06 = Medicare blood deductible — Total cash blood deductible (Part A blood deductible).

07 = Medicare cash deductible reserved for national assignment.

08 = Medicare Part A lifetime reserve amount in first calendar year — Lifetime reserve amount charged in the year of admission.

09 = Medicare Part A coinsurance amount in the first calendar year — Coinsurance amount charged in the year of admission.

10 = Medicare Part A lifetime reserve amount in the second calendar year — Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.

11 = Medicare Part A coinsurance amount in the second calendar year — Coinsurance amount charged in the year of discharge where the bill spans two calendar years.

12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.

13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.

14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment.

15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.

16 = That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.

17 = Operating Outlier amount — Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry).

18 = Operating Disproportionate share amount — Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry).

19 = Operating Indirect medical education amount — Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry).

20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

21 = Catastrophic — Medicaid — Eligibility requirements to be determined at state level.

22 = Surplus — Medicaid — Eligibility requirements to be determined at state level.

23 = Recurring monthly income — Medicaid — Eligibility requirements to be determined at state level.

24 = Medicaid rate code — Medicaid — Eligibility requirements to be determined at state level.

25 = Offset to the Patient Payment Amount (Prescription Drugs) — Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).

26 = Prescription Drugs Offset to Patient (Payment Amount — Hearing and Ear Services) Hearing and ear services paid for out of a long-term care facility

resident/patient's funds in the billing period submitted (Statement covers period).

27 = Offset to the Patient (Payment Amount — Vision and Eye Services) — Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).

28 = Offset to the Patient (Payment Amount — Dental Services) — Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).

29 = Offset to the Patient (Payment Amount — Chiropractic Services) — Chiropractic services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).

30 = Preadmission Testing — the code used to reflect the charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.

31 = Patient liability amount — Amount shown is that which you or the PRO approved to charge the bene for non-covered accommodations, diagnostic procedures, or treatments.

32 = Multiple patient ambulance transport — The number of patients transported during one ambulance ride to the same destination. (eff. 4/1/2003)

33 = Offset to the Patient Payment Amount (Podiatric Services) — Podiatric services paid out of a long-term care facility resident/patient's funds in the billing period submitted.

34 = Offset to the Patient Payment Amount (Medical Services) — Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.

35 = Offset to the Patient Payment Amount (Health Insurance Premiums) — Other medical services paid out of a long-term care facility resident/ patient's funds in the billing period submitted.

37 = Pints of blood furnished — Total number of pints of whole blood or units of packed red cells furnished to the patient.

38 = Blood deductible pints — The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.

39 = Pints of blood replaced — The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient.

40 = New coverage not implemented by HMO — amount shown is for inpatient charges covered by HMO. (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.

41 = Amount is that portion of a payment from higher priority BL

program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.

42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.

43 = Disabled bene under age 65 with LGHP — Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.

44 = Amount provider agreed to accept from primary payer when amount less than charges, but more than payment received — When a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due.

45 = Accident Hour — The hour the accident occurred that necessitated medical treatment.

46 = Number of grace days — Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care.

47 = Any liability insurance — Amount is that portion from a higher priority liability insurance made on behalf of Medicare bene the provider is applying to Medicare covered services on this bill.

48 = Hemoglobin reading — The patient's most recent hemoglobin reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during the billing cycle.

49 = Hematocrit reading — The patient's most recent hematocrit reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing cycle.

50 = Physical therapy visits — Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.

51 = Occupational therapy visits — Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.

52 = Speech therapy visits — Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.

53 = Cardiac rehabilitation — Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.

54 = New birth weight in grams — Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of '4' and on other claims as required by law.

55 = Eligibility Threshold for Charity Care — code identifies the corresponding value amount at which a health care facility determines the eligibility threshold of charity care.

56 = Hours skilled nursing provided — The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.

57 = Home health visit hours — The number of home health aide services provided during the billing period. Count only the hours spent in the home.

58 = Arterial blood gas — Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

59 = Oxygen saturation — Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

60 = HHA branch MSA — MSA in which HHA branch is located.

61 = Location of HHA service or hospice service — the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider. **NOTE:** HHA claims with a thru date on or before 12/31/2005, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/2005, the value code amount field reflects the CBSA code.

62 = Number of Part A home health visits accrued during a period of continuous care — necessitated by the change in payment basis under HH PPS (eff. 10/2000)

63 = Number of Part B home health visits accrued during a period of continuous care — necessitated by the change in payment basis under HH PPS (eff. 10/2000)

64 = HH re-imbursement. Amount of home health payments attributed to the Part A trust fund in a period of continuous care — necessitated by the change in payment basis under HH PPS (eff. 10/2000)

65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care — necessitated by the change in payment basis under HH PPS (eff. 10/2000)

66 = Medicare Spend-down Amount — The dollar amount that was used to meet the recipient's spend-down liability for this claim.

67 = Peritoneal dialysis — The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home).

68 = EPO drug — Number of units of EPO administered relating to the billing period.

69 = State charity Care Percent — code indicates the percentage of

charity care eligibility for the patient.

70 = Interest amount — (Providers do not report this.) Report the amount applied to this bill.

71 = Funding of ESRD networks — (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.

72 = Flat rate surgery charge — Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.

73 = Drug deductible — (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.

74 = Drug coinsurance — (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.

75 = Gramm/Rudman/Hollings — (Providers do not report this.) Report the amount of the sequestration applied to this bill.

76 = Provider's Interim Rate. Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only). An interim rate of 50 percent is entered as follows: 50.00.

77 = New Technology Add-on Payment Amount — Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary. (eff. 4/1/2003, under Inpatient PPS)

78 = Payer code — This code is set aside for payer use only. Providers do not report these codes.

79 = Payer code — This code is set aside for payer use only. Providers do not report these codes.

80 = Covered Days. The number of days covered by the primary payer.

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

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

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

84 = Medicare Lifetime Reserve Amount in the third or greater calendar years. (eff. 1/7/2013

85 = Medicare Coinsurance Amount in the third or greater calendar years. (eff. 1/7/2013)

86 = Invoice Cost (for CAR T-cells) (eff. 04/2019, term. 3/2020)

87 = Gene Therapy Invoice Cost (eff. 4/2020)

88 = Allogeneic Stem Cell Transplant — Number of Related Donors Evaluation (eff. 7/2020)

89 = Allogeneic Stem Cell Transplant — Total All-inclusive Donor Charges (eff. 7/2020)

90 = Cell Therapy Invoice Cost (eff. 4/2020)

91–99 = Reserved for national assignment.

A0 = Special Zip Code Reporting — five-digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/2001)

A1 = Deductible Payer A — The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (eff. 10/1993) — Prior value 0

A2 = Coinsurance Payer A — The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer.

A3 = Estimated Responsibility Payer A — The amount estimated by the provider to be paid by the indicated payer.

A4 = Self-administered drugs administered in an emergency situation — Ordinarily the only non-covered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma.

A5 = Covered self-administered drugs — The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to the patient.

A6 = Covered self-administered drugs — Diagnostic study and Other — the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.

A7 = Copayment A — The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

A8 = Patient Weight — Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.

A9 = Patient Height — Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.

AA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) — The amount of regulatory

surcharges, assessments, allowances, or health care related taxes pertaining to the indicated payer (eff. 10/2003).

AB = Other Assessments or Allowances (Payer A) — The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

B1 = Deductible Payer B — The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff. 10/1993) — Prior value 07

B2 = Coinsurance Payer B — the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer.

B3 = Estimated Responsibility Payer B — The amount estimated by the provider to be paid by the indicated payer.

B7 = Copayment B — The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

BA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) — The amount of regulatory surcharges, assessments, allowances, or health care related taxes pertaining to the indicated payer (eff. 10/2003).

BB = Other Assessments or Allowances (Payer B) — The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

C1 = Deductible Payer C — The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff. 10/1993) — Prior value 07

C2 = Coinsurance Payer C — The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer.

C3 = Estimated Responsibility Payer C

C7 = Copayment C — The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) — The amount of regulatory surcharges, assessments, allowances, or health care related taxes pertaining to the indicated payer (eff. 10/2003).

CB = Other Assessments or Allowances (Payer C) — The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

D3 = Estimated Responsibility Patient — The amount estimated by the provider to be paid by the indicated patient.

D4 = Clinical Trial Number Assigned by NLM/NIH — Eight-digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 10/1/2007)

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

E1 = Deductible Payer D

E3 = Estimated Responsibility Payer D

F1 = Deductible Payer E

F2 = Coinsurance Payer E

F3 = Estimated Responsibility Payer E

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

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

G1 = Deductible Payer F

G2 = Coinsurance Payer F

G3 = Estimated Responsibility Payer F

G8 = Facility Where Inpatient Hospice Service Is Delivered — MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08)

GA = Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer F

Q0 = ACO Payment Adjustment Amount (Pioneer Reduction) — the amount that would have been paid if not for the Pioneer reduction. (eff. 1/2014)

Q1 = ACO Payment Reduction Amount (Pioneer Reduction) — the actual amount of the Pioneer reduction. (eff. 1/2014)

Q4 = Pennsylvania (PA) Rural Health Exclusion — Physician Services Claim Reimbursement

Q5 = Electronic health record (EHR)-Reduction

Q7 = Islet Add-On Payment Amount (eff. 10/2016)

Q8 = Total Transitional Drug Add-On Payment Adjustment (TDAPA) Amount (eff. 1/2018)

Q9 = Medicare Advantage (MA) Plan Amount (eff. 10/2014

QB = OCM+ Payment Adjustment Amount (payer only) — eff. 1/2020

QN = First APC device offset

QO = Second APC device offset

QP = Reserved for future use

QQ = Terminated procedure with pass-through device OR condition for device credit present

QR = First APC pass-through drug or biological offset

QS = Second APC pass-through drug or biological offset

QT = Third APC pass-through drug or biological offset

QU = Reserved for future use

QV = Home Health Value Based Purchasing (HHVBP) adjustment amount (negative or positive; eff. 4/2018)

QW = Reserved for future use

XX = Total Charge Amount for all Part A visits on RIC 'U' claims — for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part A visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, and 057X). Code created internally in the NCHMQA system (eff. 10/31/2001 with HHPPS).

XY = Total Charge Amount for all Part B visits on RIC 'U' claims — for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part B visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, and 057X). Code created internally in the NCHMQA system (eff. 10/31/2001 with HHPPS).

XZ = Total Charge Amount for all Part B non-visit charges on the RIC 'U' claims — for Home Health claims containing both Part A and Part B services, this code identifies the total charge amount for the Part B non-visit charges. Code created internally in the NCHMQA system (eff. 10/31/2001 with HHPPS).

Y1 = Part A demo payment — Portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.

Y2 = Part B demo payment — Portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.

Y3 = Part B coinsurance — Amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

Y4 = Conventional Provider Payment Amount for Non-Demonstration Claims — This the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass-through amounts such as that for direct medical education nor interim payments for operating IME and DSH.

Y5 = Part B deductible, applicable for a Model 4 demonstration 64 claims

COMMENT: —

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CLM_VBP_ADJSTMT_PCT

LABEL: Claim VBP Adjustment Percent

DESCRIPTION: Under the Hospital Value Based Purchasing (HVBP) program, an adjustment is made to the base operating DRG amount for certain Inpatient Prospective Payment System (IPPS) hospitals — based on their Total Performance Score (TPS).

SHORT NAME: CLM_VBP_ADJSTMT_PCT

LONG NAME: CLM_VBP_ADJSTMT_PCT

TYPE: NUM

LENGTH: 15

SOURCE: NCH

VALUES: X.XX

COMMENT: This initiative began in 4th Quarter of 2013 (i.e., beginning of Federal fiscal year 14 [FY14]).

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

The HVBP applies only to subsection (d) IPPS hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (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 4th Quarter of 2013 (i.e., beginning of Federal fiscal year 14 [FY14]). This field was new in 2013 and is null/missing for all previous years.

The HVBP applies only to subsection (d) Inpatient Prospective Payment System (IPPS) hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (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 4th 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: NHCMQ (RUGS) Demo — testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

02 = National HHA Prospective Payment Demo — testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

03 = Telemedicine Demo — testing covering traditionally non-covered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

04 = United Mine Workers of America (UMWA) Managed Care Demo — testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the three-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

05 = Medicare Choices (MCO encounter data) demo — testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site. **NOTE:** This demonstration was terminated 12/31/2000.

06 = Coronary Artery Bypass Graft (CABG) Demo — testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'. **NOTE:** This

demonstration was terminated in 1998.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) — this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'. **NOTE:** The implementation date for this demonstration is 4/1/2003.

08 = Provider Partnership Demo — testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

15 = ESRD Managed Care (MCO encounter data) — testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study — evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

31 = VA Pricing Special Processing (SPN) — not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing — NCH WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31' BUT WILL NOT TRANSMIT TO HCFA (CMS) (not in Nearline File).

37 = Medicare Coordinated Care Demonstration — to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a

provider number specifically for the demonstration services.

37 = Medicare Disease Management (DMD) — the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare diagnosed, beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (eff. 4/1/2003).

38 = Physician Encounter Claims — the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. **NOT IN NCH.** **NOTE:** Effective October 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims — The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing. **NOTE:** Effective October 2000 for carrier claims.

40 = Payment of Physician and Non-physician Services in certain Indian Providers — the purpose of this demo is to extend payment for services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule. **NOTE:** Effective July 1, 2001 for institutional and carrier claims.

45 = Chiropractic

48 = Medical Adult Day-Care Services — the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries' home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home. **NOTE:** Effective July 5, 2005 for HHA claims.

49 = Hemodialysis

53 = Extended Stay

54 = ACE Demo

56 = ACA 3113 Lab Demo

58 = used to identify the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration. (eff. 7/2/12)

59 = ACO Pioneer Demonstration (eff. 1/2014)

60 = PMD (Power Motorized Vehicle)

61 = CLM-CARE-IMPRVMT-MODEL-1

62 = CLM-CARE-IMPRVMT-MODEL-2

63 = CLM-CARE-IMPRVMT-MODEL-3

64 = CLM-CARE-IMPRVMT-MODEL-4

65 = rebilled claims due to auditor denials — code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12)

66 = rebilled claims due to provider self-audit after claim submission/payment — code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12)

67 = rebilled claims due to provider self-audit after the patient has been discharged, but prior to payment — code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12)

68 = NCH will not apply the three-day hospital stay requirement when processing a SNF claim. (eff. 1/2014)

70 = used for Electrical Workers Insurance Fund claims. (eff. 7/2/12)

71 = IVIG (Intravenous Immunoglobulin)

74 = unknown value

77 = Shared Savings Program (eff. 10/2016)

78 = Comprehensive Primary Care Plus (CPC+) (eff. 4/2017)

79 = Acute Myocardial Infarction (AMI) Episode Payment Model (EPM) (eff. 1/2018)

80 = Coronary Artery Bypass Graft (CABG) Episode Payment Model (EPM) (eff. 1/2018)

81 = Surgical Hip and Femur Fracture Treatment (SHFFT) Episode Payment Model (EMP) (eff. 1/2018)

82 = Medicare Diabetes Prevention Program (MDPP) (eff. 4/2018)

83 = Maryland Primary Care Program (MDPCP) (eff. 1/2018)

87 = Radiation Oncology (RO) Model (eff. 10/2019)

91 = Emergency Triage, Treat and Transport (ET3) Model (eff. 1/2020)

94 = ESRD Treatment Choices (ETC) (eff. 1/2020) — Outpatient and Carrier Only

95 = Oncology Care Model Plus (OCM+) (eff. 1/2020)

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 = California
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
67 = Texas
68 = Florida (eff. 10/2005)
69 = Florida (eff. 10/2005)
70 = Kansas (eff. 10/2005)
71 = Louisiana (eff. 10/2005)
72 = Ohio (eff. 10/2005)
73 = Pennsylvania (eff. 10/2005)
74 = Texas (eff. 10/2005)
80 = Maryland (eff. 8/2000)
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa; otherwise unknown

COMMENT: —

^ 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 SSN's are shown in the physician ID code field.

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

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

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

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

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

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

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

COMMENT: —

^ 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: —

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DSH_OP_CLM_VAL_AMT

LABEL: Operating Disproportionate Share (DSH) Amount

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

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

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

SHORT NAME: DSH_OP

LONG NAME: DSH_OP_CLM_VAL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: http://www.medpac.gov/payment_basics.cfm).

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

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

^ 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.

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EHR_PYMT_ADJSTMT_AMT

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

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

SHORT NAME: EHR_PYMT_ADJSTMT_AMT

LONG NAME: EHR_PYMT_ADJSTMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

^ 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: —

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FI_NUM

LABEL: FI or MAC Number

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

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

SHORT NAME: FI_NUM

LONG NAME: FI_NUM

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

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

Reference the CMS website for MAC Contract Status (for example):
http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACContractStatus.html

Fiscal Intermediary Numbers (as of June 2004):

State	Contract	Contractor	Identifier
Multiple	FI	Mutual of Omaha	52280
Alabama	FI	Cahaba	00010
Alaska	FI	Noridian	00322
Arizona	FI	BCBS Arizona	00030
Arkansas	FI	BCBS Arkansas	00020
California	FI	UGS	00454
Colorado	FI	TrailBlazer	00400
Connecticut	FI	Empire	00308
Delaware	FI	Empire	00308
D.C.	FI	Carefirst of MD	00190
Florida	FI	First Coast	00090
Georgia	FI	BCBS Georgia	00101
Hawaii (Includes Guam and American Samoa)	FI	UGS	00454
Idaho	FI	Regence	00350
Illinois	FI	AdminaStar	00131
Indiana	FI	AdminaStar	00130
Iowa	FI	Cahaba	00011
Kansas	FI	BCBS Kansas	00150
Kentucky	FI	AdminaStar	00160
Louisiana	FI	Trispan	00230
Maine	FI	Associated Hospital of ME	00180

State	Contract	Contractor	Identifier
Maryland	FI	Carefirst of Maryland	00190
Massachusetts	FI	Associated Hospital of ME	00181
Michigan	FI	UGS	00452
Minnesota	FI	Noridian	00320
Mississippi	FI	Trispan	00230
Missouri	FI	Trispan	00230
Montana	FI	BCBS Montana	00250
Nebraska	FI	BCBS Nebraska	00260
Nevada	FI	UGS	00454
New Hampshire	FI	BCBS NH/VT	00270
New Jersey	FI	Riverbend	00390
New Mexico	FI	TrailBlazer	00400
New York	FI	Empire	00308
North Carolina	FI	Palmetto	00382
North Dakota	FI	Noridian	00320
Ohio	FI	AdminaStar	00332
Oklahoma		BCBS Oklahoma	00340
Oregon	FI	Regence	00350
Pennsylvania	FI	Veritus	00363
Puerto Rico (Includes Virgin Islands)	FI	Cooperativa	57400
Rhode Island	FI	Arkansas BCBS	00021
South Carolina	FI	Palmetto	00380
South Dakota	FI	Cahaba	00011
Tennessee	FI	Riverbend	00390
Texas	FI	TrailBlazer	00400
Utah	FI	Regence	00350
Vermont	FI	BCBS NH/VT	00270
Virginia	FI	UGS	00453
Washington	FI	Noridian	00322
West Virginia	FI	UGS	00453
Wisconsin	FI	UGS	00450
Wyoming	FI	BCBS Wyoming	00460

COMMENT: —

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FINL_STD_AMT

LABEL: Claim Final Standard Payment Amount

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

SHORT NAME: FINL_STD_AMT

LONG NAME: FINL_STD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XX.XX

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

This field 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.

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GNDR_CD

LABEL: Gender Code from Claim

DESCRIPTION: The sex of a beneficiary.

SHORT NAME: GNDR_CD

LONG NAME: GNDR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: SSA, RRB, EDB

VALUES: 0 = Unknown
1 = Male
2 = Female

COMMENT: —

^ 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 5-position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5-position alpha-numeric codes representing primarily items and non-physician services that are not represented in the level I codes.

Level III

Codes and descriptors developed by Medicare carriers (currently known as Medicare Administrative Contractors; MACs) for use at the local (MAC) level. These are 5-position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in the level I or level II codes.

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

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

For home health claims, please also 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_CD7
ICD_DGNS_E_CD2	ICD_DGNS_E_CD8
ICD_DGNS_E_CD3	ICD_DGNS_E_CD9
ICD_DGNS_E_CD4	ICD_DGNS_E_CD10
ICD_DGNS_E_CD5	ICD_DGNS_E_CD11
ICD_DGNS_E_CD6	ICD_DGNS_E_CD12

LONG NAME:

ICD_DGNS_E_CD1	ICD_DGNS_E_CD7
ICD_DGNS_E_CD2	ICD_DGNS_E_CD8
ICD_DGNS_E_CD3	ICD_DGNS_E_CD9
ICD_DGNS_E_CD4	ICD_DGNS_E_CD10
ICD_DGNS_E_CD5	ICD_DGNS_E_CD11
ICD_DGNS_E_CD6	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: http://www.medpac.gov/payment_basics.cfm)

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

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

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LINE_1ST_EXPNS_DT

LABEL: Line First Expense Date

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

SHORT NAME: EXPNSDT1

LONG NAME: LINE_1ST_EXPNS_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

^ Back to TOC ^

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).

^ Back to TOC ^

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: —

^ Back to TOC ^

LINE_BENE_PRMRY_PYR_CD

LABEL: Line Primary Payer Code (if not Medicare)

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

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

SHORT NAME: LPRPAYCD

LONG NAME: LINE_BENE_PRMRY_PYR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH, VA, DOL, SSA

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

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

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LINE_BENE_PRMRY_PYR_PD_AMT

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

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

SHORT NAME: LPRPDAMT

LONG NAME: LINE_BENE_PRMRY_PYR_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

^ Back to TOC ^

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: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html).

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LINE_DME_PRCHS_PRICE_AMT

LABEL: Line DME Purchase Price Amount

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

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

SHORT NAME: DME_PURC

LONG NAME: LINE_DME_PRCHS_PRICE_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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LINE_HCT_HGB_RSLT_NUM

LABEL: Hematocrit/Hemoglobin Test Results

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

SHORT NAME: HCTHGBRS

LONG NAME: LINE_HCT_HGB_RSLT_NUM

TYPE: NUM

LENGTH: 4

SOURCE: NCH

VALUES: —

COMMENT: This variable became effective 9/1/2008 to comply with CR# 5699.

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

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LINE_HCT_HGB_TYPE_CD

LABEL: Hematocrit/Hemoglobin Test Type Code

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

SHORT NAME: HCTHGBTP

LONG NAME: LINE_HCT_HGB_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: R1 = Hemoglobin Test
R2 = Hematocrit Test

COMMENT: This variable became effective 9/1/2008 to comply with CR# 5699.

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

^ Back to TOC ^

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.

^ Back to TOC ^

LINE_LAST_EXPNS_DT

LABEL: Line Last Expense Date

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

^ Back to TOC ^

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: —

^ Back to TOC ^

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_AMT2
LINE_OTHR_APLD_AMT3
LINE_OTHR_APLD_AMT4
LINE_OTHR_APLD_AMT5
LINE_OTHR_APLD_AMT6
LINE_OTHR_APLD_AMT7

LONG NAME:

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

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 7 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 = Part B Drug Payment Model
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

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_PLACE_OF_SRVC_CD

LABEL: Line Place of Service Code

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

SHORT NAME: PLCSRVC

LONG NAME: LINE_PLACE_OF_SRVC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
01 = Pharmacy. A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02 = Telehealth. The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
03 = School. A facility whose primary purpose is education.
04 = Homeless Shelter. A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05 = Indian Health Service — Free-standing Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06 = Indian Health Service — Provider-based Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07 = Tribal 638 — Free-standing Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08 = Tribal 638 Provider-based Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 = Prison/Correctional Facility. A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10 = Unassigned. N/A
11 = Office. Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12 = Home. Location, other than a hospital or other facility, where the patient receives care in a private residence.

13 = Assisted Living Facility. Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14 = Group Home. A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15 = Mobile Unit. A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 = Temporary Lodging. A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17 = Walk-in Retail Health Clinic. A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive, and primary care services.
18 = Place of Employment — Worksite. 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 effective January 1, 2013 but no later than May 1, 2013)
19 = Off Campus — Outpatient Hospital. A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 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. A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22 = Outpatient Hospital. A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23 = Emergency Room — Hospital. A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24 = Ambulatory Surgical Center. A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25 = Birthing Center. A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26 = Military Treatment Facility. A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27 = Unassigned. N/A
28 = Unassigned. N/A
29 = Unassigned. N/A
30 = Unassigned. N/A

31 = Skilled Nursing Facility. A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32 = Nursing Facility. A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33 = Custodial Care Facility. A facility which provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34 = Hospice. A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35–40 = Unassigned. N/A
41 = Ambulance — Land. A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42 = Ambulance — Air or Water. An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
43–48 = Unassigned. N/A
49 = Independent Clinic. A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/2003)
50 = Fed Qualified Health Ctr. A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51 = Inpatient Psych Facility. A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52 = Psychiatric Facility — Partial Hospitalization. A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53 = Community Mental Health Ctr. A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54 = Intermediate Care/Mentally Retarded Facility. A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55 = Residential Substance Abuse Treatment Facility. A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56 = Psychiatric Residential Treatment Center. A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57 = Non-residential Substance Abuse Treatment Facility. A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group

therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

58 = Unassigned. N/A

59 = Unassigned. N/A

60 = Mass Immunization Center. A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

61 = Comprehensive Inpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 = Comprehensive Outpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63 = Unassigned. N/A

64 = Unassigned. N/A

65 = End-Stage Renal Disease Treatment Facility. A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

66–70 = Unassigned. N/A

71 = Public Health Clinic. A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 = Rural Health Clinic. A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

73–80 = Unassigned. N/A

81 = Independent Laboratory. A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

82–98 = Unassigned. N/A

99 = Other Place of Service. Other place of service not identified above.

COMMENT: —

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LINE_PMT_80_100_CD

LABEL: Line Payment 80%/100% Code

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

SHORT NAME: PMTINDSW

LONG NAME: LINE_PMT_80_100_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —

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LINE_PRCSG_IND_CD

LABEL: Line Processing Indicator Code

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

SHORT NAME: PRCNGIND

LONG NAME: LINE_PRCSG_IND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
A = Allowed
B = Benefits exhausted
C = Non-covered care
D = Denied (from BMAD)
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_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.

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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.

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LINE_SBMTD_CHRG_AMT

LABEL: Line Submitted Charge Amount

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

Providers' submitted charges often differ from the amount they were eventually paid — either from Medicare, the beneficiary (through deductible or coinsurance amounts) or third-party payers.

SHORT NAME: LSBMTCHG

LONG NAME: LINE_SBMTD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

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LINE_SERVICE_DEDUCTIBLE

LABEL: Line Service Deductible Indicator Switch

DESCRIPTION: Switch indicating whether or not the line-item service on the non-institutional claim is subject to a deductible.

SHORT NAME: DED_SW

LONG NAME: LINE_SERVICE_DEDUCTIBLE

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = Service Subject to Deductible
1 = Service Not Subject to Deductible

COMMENT: —

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LINE_SRVC_CNT

LABEL: Line Service Count

DESCRIPTION: The count of the total number of services processed for the line item on the non-institutional claim.

SHORT NAME: SRVC_CNT

LONG NAME: LINE_SRVC_CNT

TYPE: NUM

LENGTH: 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.

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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.

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NCH_ACTV_OR_CVRD_LVL_CARE_THRU

LABEL: NCH Active or Covered Level Care Thru Date

DESCRIPTION: The date on a claim for which the covered level of care ended in a general hospital or the active care ended in a psychiatric/tuberculosis hospital.

SHORT NAME: CARETHRU

LONG NAME: NCH_ACTV_OR_CVRD_LVL_CARE_THRU

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: This variable is derived, using the occurrence code (variable called CLM_RLT_OCRNC_CD), when the value is 22. When this code value is present the date is populated using the CLM_RLT_OCRNC_DT.

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NCH_BENE_BLOOD_DDCTBL_LBLTY_AM

LABEL: NCH Beneficiary Blood Deductible Liability Amount

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

A blood deductible amount applies to the first 3 pints of blood (or equivalent units; applies only to whole blood or packed red cells — not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

SHORT NAME: 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.

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NCH_BENE_DSCHRG_DT

LABEL: NCH Beneficiary Discharge Date

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

Date matches the "thru" date on the claim (CLM_THRU_DT). When there is a discharge date, the discharge status code (PTNT_DSCHRG_STUS_CD) indicates the final disposition of the patient after discharge.

SHORT NAME: DSCHRGDT

LONG NAME: NCH_BENE_DSCHRG_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: —

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NCH_BENE_IP_DDCTBL_AMT

LABEL: NCH Beneficiary Inpatient (or other Part A) Deductible Amount

DESCRIPTION: The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.

Under Part A, the deductible applies only to inpatient hospital care (whether in an acute care facility, Inpatient psychiatric facility [IPF], inpatient rehabilitation facility [IRF], or long-term care hospital [LTCH]) and is charged only at the beginning of each benefit period, which is similar to an episode of illness.

This variable is null/missing for skilled nursing facility (SNF), home health, and hospice claims.

SHORT NAME: DED_AMT

LONG NAME: NCH_BENE_IP_DDCTBL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Costs to beneficiaries are described in detail on the Medicare.gov website.

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NCH_BENE_MDCR_BNFTS_EXHTD_DT_I

LABEL: NCH Beneficiary Medicare Benefits Exhausted Date

DESCRIPTION: The last date for which the beneficiary has Medicare coverage.

This is completed only where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim.

SHORT NAME: EXHST_DT

LONG NAME: NCH_BENE_MDCR_BNFTS_EXHTD_DT_I

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: Derived from: CLM_RLT_OCRNC_CD and CLM_RLT_OCRNC_DT

Derivation rules: Based on the presence of occurrence code A3, B3 or C3 move the related occurrence date to NCH_MDCR_BNFT_EXHST_DT.

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

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

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NCH_CARR_CLM_SBMTD_CHRG_AMT

LABEL: NCH Carrier Claim Submitted Charge Amount (sum of all line-level submitted charges)

DESCRIPTION: The total submitted charges on the claim (sum of all line-level submitted charges, variable called LINE_SBMTD_CHRG_AMT).

SHORT NAME: SBMTCHRG

LONG NAME: NCH_CARR_CLM_SBMTD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: XXX.XX

COMMENT: The charges the provider submits may be different than the amount that Medicare or a secondary payer will allow for the claim — and this amount is also different than the actual Medicare or beneficiary paid amounts.

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

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

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

Also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference the list of MLN publications at: http://www.cms.gov/Outreach-and-ducation/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.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 http://www.medpac.gov/payment_basics.cfm).

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

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NCH_CLM_TYPE_CD

LABEL: NCH Claim Type Code

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

SHORT NAME: CLM_TYPE

LONG NAME: NCH_CLM_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
10 = Home Health Agency (HHA) claim
20 = Non swing bed Skilled Nursing Facility (SNF) claim
30 = Swing bed SNF claim
40 = Hospital Outpatient claim
50 = Hospice claim
60 = Inpatient claim
71 = Local carrier non-durable medical equipment, 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"

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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.

^ Back to TOC ^

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: —

^ 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.

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NCH_WKLY_PROC_DT

LABEL: NCH Weekly Claim Processing Date

DESCRIPTION: The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

SHORT NAME: WKLY_DT

LONG NAME: NCH_WKLY_PROC_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —

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OP_PHYSN_NPI

LABEL: Claim Operating Physician NPI Number

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

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

SHORT NAME: OP_NPI

LONG NAME: OP_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/2007 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. 4/1/2003)

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. 4/1/2003 — 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 = 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 orthoptist

56 = Individual certified prosthetist

57 = Individual certified prosthetist-orthotist

58 = Medical supply company with registered pharmacist

59 = Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)

60 = Public health or welfare agencies (federal, state, and local)

61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)

62 = Psychologist (billing independently)

63 = Portable X-ray supplier

64 = Audiologist (billing independently)

65 = Physical therapist (private practice added 4/1/2003) (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 = 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)

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 7/1/2006, 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. 10/2/2007)

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)

COMMENT: —

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OP_PHYSN_UPIN

LABEL: Claim Operating Physician UPIN Number

DESCRIPTION: On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.

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

SHORT NAME: OP_UPIN

LONG NAME: OP_PHYSN_UPIN

TYPE: CHAR

LENGTH: 6

SOURCE: NCH

VALUES: —

COMMENT: —

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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.

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ORG_NPI_NUM

LABEL: Organization (or group) NPI Number

DESCRIPTION: The National Provider Identifier (NPI) of the organization or group practice.

SHORT NAME: ORGNPINM

LONG NAME: ORG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: On an institutional claim, this is the NPI number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

On the carrier claim, this is line-level information regarding the performing physician (Short Name = PRGRPNPI); it is the NPI of the group practice, where the performing physician is part of that group.

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OT_PHYSN_NPI

LABEL: Claim Other Physician NPI Number

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

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

SHORT NAME: OT_NPI

LONG NAME: OT_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/2007 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. 4/1/2003)

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. 4/1/2003—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 = 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 = 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)

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 (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)

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: —

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PHYSN_ZIP_CD

LABEL: Line Place of Service (POS) Physician Zip Code

DESCRIPTION: The 9-digit zip code for the primary practice/business location of the physician receiving the payment or other transfer of value.

SHORT NAME: PHYSN_ZIP_CD

LONG NAME: PHYSN_ZIP_CD

TYPE: CHAR

LENGTH: 15

SOURCE: NCH

VALUES: —

COMMENT: —

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PPS_STD_VAL_PYMT_AMT

LABEL: Standard Payment Amount

DESCRIPTION: This amount identifies the standardized Medicare payment amount.

SHORT NAME: PPS_STD_VAL_PYMT_AMT

LONG NAME: PPS_STD_VAL_PYMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

This field is new in October 2014. This field 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: —

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PRF_PHYSN_NPI

LABEL: Carrier Line Performing NPI Number

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

SHORT NAME: PRFNPI

LONG NAME: PRF_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Effective May 2007, the NPI became the national standard identifier for covered health care providers. NPIs replaced the legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions.

The UPIN is almost never populated after 2009.

^ 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: —

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PRNCPAL_DGNS_CD

LABEL: Claim Principal Diagnosis Code

DESCRIPTION: The diagnosis code identifying the diagnosis, condition, problem, or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

This data is also redundantly stored as the first occurrence of the diagnosis code (variable called ICD_DGNS_CD1).

SHORT NAME: PRNCPAL_DGNS_CD

LONG NAME: PRNCPAL_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

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

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

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

^ 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.

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PRTCPTNG_IND_CD

LABEL: Line Provider Participating Indicator Code

DESCRIPTION: Code indicating whether or not a provider is participating (accepting assignment) for this line-item service on the non-institutional claim.

SHORT NAME: PRTCPTG

LONG NAME: PRTCPTNG_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
1 = Participating
2 = All or some covered and allowed expenses applied to deductible Participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating.
6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating.
7 = Participating provider not accepting assignment

COMMENT: —

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PRVDR_NPI

LABEL: DMERC Line-Item Supplier NPI Number

DESCRIPTION: The National Provider Identifier (NPI) assigned to the supplier of the Part B service/DMEPOS line item.

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

SHORT NAME: SUP_NPI

LONG NAME: PRVDR_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —

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PRVDR_NUM (Institutional claim)

LABEL: Provider Number

DESCRIPTION: This variable is the provider identification number.

The first two digits indicate the state where the provider is located, using the SSA state codes; the middle two characters indicate the type of provider; and the last two digits are used as a counter for the number of providers within that state and type of provider (i.e., this is a unique but not necessarily sequential number).

SHORT NAME: PROVIDER

LONG NAME: PRVDR_NUM

TYPE: CHAR

LENGTH: 6

SOURCE: —

VALUES: The following blocks of numbers are reserved for the facilities indicated

(**NOTE:** may have different meanings dependent on the Type of Bill [TOB]):

0001–0879: Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X

0880–0899: Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X

0900–0999: Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X

1000–1199: Reserved for future use

1200–1224: Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X

1225–1299: Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X

1300–1399: Critical Access Hospitals (CAH)

1400–1499: Continuation of 4900–4999 series (CMHC)

1500–1799: Hospices

1800–1989: Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X

1990–1999: Religious Nonmedical Health Care Institutions (RNHCI)

2000–2299: Long-term hospitals

2300–2499: Chronic renal disease facilities (hospital based)

2500–2899: Non-hospital renal disease treatment centers

2900–2999: Independent special purpose renal dialysis facility (1)

3000–3024: Formerly tuberculosis hospitals (numbers retired)

3025–3099: Rehabilitation hospitals

3100–3199: Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3)

3200–3299: Continuation of 4800-4899 series (CORF)

3300–3399: Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X

3400–3499: Continuation of rural health clinics (provider-based) (3975-3999)

3500–3699: Renal disease treatment centers (hospital satellites)

3700–3799: Hospital based special purpose renal dialysis facility (1)

3800–3974: Rural health clinics (free-standing)

3975–3999: Rural health clinics (provider-based)

4000–4499: Psychiatric hospitals

4500–4599: Comprehensive Outpatient Rehabilitation Facilities (CORF)

4600–4799: Community Mental Health Centers (CMHC)

4800–4899: Continuation of 4500–4599 series (CORF)

4900–4999: Continuation of 4600–4799 series (CMHC)

5000–6499: Skilled Nursing Facilities

6500–6989: CMHC/Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X

6990–6999: Numbers Reserved (formerly Christian Science)

7000–7299: Home Health Agencies (HHA) (2)

7300–7399: Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)

7400–7799: Continuation of 7000–7299 series

7800–7999: Subunits of state and local governmental Home Health Agencies (3)

8000–8499: Continuation of 7400–7799 series (HHA)

8500–8899: Continuation of rural health center (provider based) (3400–3499)

8900–8999: Continuation of rural health center (free-standing) (3800–3974)

9000–9799: Continuation of 8000–8499 series (HHA)

9800–9899: Transplant Centers (eff. 10/1/2007)

9900–9999: Reserved for future use

NOTE: There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

M = Psychiatric Unit in Critical Access Hospital

R = Rehabilitation Unit in Critical Access Hospital

S = Psychiatric unit (excluded from PPS)

T = Rehabilitation unit (excluded from PPS)

U = Swing-Bed Hospital Designation for Short-Term Hospitals

V = Alcohol drug unit (prior to 10/87 only)

W = Swing-Bed Hospital Designation for Long Term Care Hospitals

Y = Swing-Bed Hospital Designation for Rehabilitation Hospitals

Z = Swing Bed Designation for Critical Access Hospitals

There is also a special numbering system for assigning emergency hospital identification numbers (non-participating hospitals).

The sixth position of the provider number is as follows:

E = Non-federal emergency hospital

F = Federal emergency hospital

COMMENT: Refer to CCW Technical Guidance document: "Getting Started with Medicare Data" for additional information regarding service setting classifications.

If you want additional information about the institutional provider, the quarterly CMS Provider of Services (POS) file contains dozens of variables that describe the characteristics of the provider. This file is updated quarterly, and effective May 2014 is available for free online from the CMS website (2005–current).

^ Back to TOC ^

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. 4/1/2003)

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. 4/1/2003 — 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 = 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 = 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)

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 (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

C6 = Hospitalist

C7 = Advanced Heart Failure and Transplant Cardiology

C8 = Medical Toxicology

C9 = Hematopoietic Cell Transplantation and Cellular Therapy

COMMENT: —

^ Back to TOC ^

PRVDR_STATE_CD

LABEL: NCH Provider SSA State Code

DESCRIPTION: The two-digit numeric social security administration (SSA) state code where provider or facility is located.

SHORT NAME: PRSTATE

LONG NAME: PRVDR_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

00 = Unknown/other
01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = California
56 = Canada 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
67 = Texas
68 = Florida (eff. 10/2005)
69 = Florida (eff. 10/2005)
70 = Kansas (eff. 10/2005)
71 = Louisiana (eff. 10/2005)
72 = Ohio (eff. 10/2005)
73 = Pennsylvania (eff. 10/2005)
74 = Texas (eff. 10/2005)
80 = Maryland (eff. 8/2000)
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa; otherwise unknown

COMMENT: When this variable appears in the Carrier file, it has a different short SAS name (PRVSTATE).

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PRVDR_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:

0 = Unknown Value (but present in data)

01 = Discharged to home/self-care (routine charge).

02 = Discharged/transferred to other short term general hospital for inpatient care.

03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care — (For hospitals with an approved swing bed arrangement, use Code 61 — swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 — ICF.

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

05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts). **NOTE:** Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.

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

07 = Left against medical advice or discontinued care.

08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/2005)

09 = Admitted as an inpatient to this hospital (effective 3/1/1991). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.

20 = Expired (patient did not recover).

21 = Discharged/transferred to court/law enforcement.

30 = Still patient.

40 = Expired at home (hospice claims only)

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

42 = Expired — place unknown (Hospice claims only)

43 = Discharged/transferred to a federal hospital (eff. 10/1/2003)

50 = Discharged/transferred to a Hospice — home.

51 = Discharged/transferred to a Hospice — medical facility.

61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/2001)

62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)

63 = Discharged/transferred to a long-term care hospital. (eff. 1/2002)

64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002)

65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).

66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/2006)

69 = Discharged/transferred to a designated disaster alternative care site (starting 10/2013; applies only to particular MS-DRGs*)

70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.

71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/2001) (discontinued eff. 10/1/2005)

72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/2001) (discontinued eff. 10/1/2005)

The following codes apply only to particular MS-DRGs*, and were new in 10/2013:

81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission.

82 = Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission.

83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission.

84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.

85 = Discharged/transferred to a designated cancer center or children’s hospital with a planned acute care hospital inpatient readmission.

86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.

87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.

88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission.

89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.

90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.

91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.

92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.

93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.

94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.

95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

COMMENT: * MS-DRG codes where additional codes were available in October 2013 are:

- 280 (Acute Myocardial Infarction, Discharged Alive with MCC),
- 281 (Acute Myocardial Infarction, Discharged Alive with CC),
- 282 (Acute Myocardial Infarction, Discharged Alive without CC/MCC), and
- 789 (Neonates, Died or Transferred to Another Acute Care Facility).

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RC_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.

^ Back to TOC ^

REV_CNTR

LABEL: Revenue Center Code

DESCRIPTION: The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary).

A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SHORT NAME: REV_CNTR

LONG NAME: REV_CNTR

TYPE: CHAR

LENGTH: 4

SOURCE: NCH

VALUES:

0001 = Total charge

0022 = SNF claim paid under PPS submitted as type of bill (TOB) 21X.

NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.

0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/2000. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).

0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/2001). This code may appear only once on a claim.

0100 = All-inclusive rate — room and board plus ancillary

0101 = All-inclusive rate — room and board

0110 = Private medical or general — general classification

0111 = Private medical or general — medical/surgical/GYN

0112 = Private medical or general — OB

0113 = Private medical or general — pediatric

0114 = Private medical or general — psychiatric

0115 = Private medical or general — hospice

0116 = Private medical or general — detoxification

0117 = Private medical or general — oncology

0118 = Private medical or general — rehabilitation

0119 = Private medical or general — other

0120 = Semi-private 2 bed (medical or general) general classification

0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN

0122 = Semi-private 2 bed (medical or general) — OB

0123 = Semi-private 2 bed (medical or general) — pediatric

0124 = Semi-private 2 bed (medical or general) — psychiatric

0125 = Semi-private 2 bed (medical or general) — hospice

0126 = Semi-private 2 bed (medical or general) — detoxification

0127 = Semi-private 2 bed (medical or general) — oncology

0128 = Semi-private 2 bed (medical or general) — rehabilitation

0129 = Semi-private 2 bed (medical or general) — other

0130 = Semi-private 3 and 4 beds — general classification

0131 = Semi-private 3 and 4 beds — medical/surgical/GYN

0132 = Semi-private 3 and 4 beds — OB

0133 = Semi-private 3 and 4 beds — pediatric

0134 = Semi-private 3 and 4 beds — psychiatric

0135 = Semi-private 3 and 4 beds — hospice

0136 = Semi-private 3 and 4 beds — detoxification

0137 = Semi-private 3 and 4 beds — oncology

0138 = Semi-private 3 and 4 beds — rehabilitation

0139 = Semi-private 3 and 4 beds — other

0140 = Private (deluxe)-general classification

0141 = Private (deluxe) — medical/surgical/GYN

0142 = Private (deluxe) — OB

0143 = Private (deluxe) — pediatric

0144 = Private (deluxe) — psychiatric

0145 = Private (deluxe) — hospice

0146 = Private (deluxe) — detoxification

0147 = Private (deluxe) — oncology

0148 = Private (deluxe) — rehabilitation

0149 = Private (deluxe) — other

0150 = Room and Board ward (medical or general) — general classification

0151 = Room and Board ward (medical or general) — medical/surgical/GYN

0152 = Room and Board ward (medical or general) — OB

0153 = Room and Board ward (medical or general) — pediatric

0154 = Room and Board ward (medical or general) — psychiatric

0155 = Room and Board ward (medical or general) — hospice

0156 = Room and Board ward (medical or general) — detoxification

0157 = Room and Board ward (medical or general) — oncology

0158 = Room and Board ward (medical or general) — rehabilitation

0159 = Room and Board ward (medical or general) — other

0160 = Other Room and Board — general classification

0164 = Other Room and Board — sterile environment

0167 = Other Room and Board — self care

0169 = Other Room and Board — other

0170 = Nursery-general classification

0171 = Nursery — newborn level I (routine)

0172 = Nursery — premature newborn-level II (continuing care)

0173 = Nursery — newborn-level III (intermediate care)

0174 = Nursery — newborn-level IV (intensive care)

0179 = Nursery — other

0180 = Leave of absence — general classification

0182 = Leave of absence — patient convenience charges billable

0183 = Leave of absence — therapeutic leave

0184 = Leave of absence-ICF mentally retarded — any reason

0185 = Leave of absence nursing home (hospitalization)

0189 = Leave of absence — other leave of absence

0190 = Subacute care — general classification

0191 = Subacute care — level I

0192 = Subacute care — level II

0193 = Subacute care — level III

0194 = Subacute care — level IV

0199 = Subacute care — other

0200 = Intensive care — general classification

0201 = Intensive care — surgical

0202 = Intensive care — medical

0203 = Intensive care — pediatric

0204 = Intensive care — psychiatric

0206 = Intensive care—post ICU; redefined as intermediate ICU

0207 = Intensive care — burn care

0208 = Intensive care — trauma

0209 = Intensive care — other intensive care

0210 = Coronary care — general classification

0211 = Coronary care — myocardial infraction

0212 = Coronary care — pulmonary care

0213 = Coronary care — heart transplant

0214 = Coronary care — post CCU; redefined as intermediate CCU

0219 = Coronary care — other coronary care

0220 = Special charges — general classification

0221 = Special charges — admission charge

0222 = Special charges — technical support charge

0223 = Special charges — UR service charge

0224 = Special charges — late discharge, medically necessary

0229 = Special charges — other special charges

0230 = Incremental nursing charge rate — general classification

0231 = Incremental nursing charge rate — nursery

0232 = Incremental nursing charge rate — OB

0233 = Incremental nursing charge rate — ICU (include transitional care)

0234 = Incremental nursing charge rate — CCU (include transitional care)

0235 = Incremental nursing charge rate — hospice

0239 = Incremental nursing charge rate — other

0240 = All-inclusive ancillary — general classification

0241 = All-inclusive ancillary — basic

0242 = All-inclusive ancillary — comprehensive

0243 = All-inclusive ancillary — specialty

0249 = All-inclusive ancillary — other inclusive ancillary

0250 = Pharmacy — general classification

0251 = Pharmacy — generic drugs

0252 = Pharmacy — nongeneric drugs

0253 = Pharmacy — take home drugs

0254 = Pharmacy — drugs incident to other diagnostic service-subject payment limit

0255 = Pharmacy — drugs incident to radiology-subject to payment limit

0256 = Pharmacy — experimental drugs

0257 = Pharmacy — non-prescription

0258 = Pharmacy- — IV solutions

0259 = Pharmacy — other pharmacy

0260 = IV therapy — general classification

0261 = IV therapy — infusion pump

0262 = IV therapy — pharmacy services

0263 = IV therapy — drug supply/delivery

0264 = IV therapy — supplies

0269 = IV therapy — other IV therapy

0270 = Medical/surgical supplies — general classification (also reference 062X)

0271 = Medical/surgical supplies — nonsterile supply

0272 = Medical/surgical supplies — sterile supply

0273 = Medical/surgical supplies — take home supplies

0274 = Medical/surgical supplies — prosthetic/orthotic devices

0275 = Medical/surgical supplies — pacemaker

0276 = Medical/surgical supplies — intraocular lens

0277 = Medical/surgical supplies — oxygen-take home

0278 = Medical/surgical supplies — other implants

0279 = Medical/surgical supplies — other devices

0280 = Oncology — general classification

0289 = Oncology — other oncology

0290 = DME (other than renal) — general classification

0291 = DME (other than renal) — rental

0292 = DME (other than renal) — purchase of new DME

0293 = DME (other than renal) — purchase of used DME

0294 = DME (other than renal) — related to and listed as DME

0299 = DME (other than renal) — other

0300 = Laboratory — general classification

0301 = Laboratory — chemistry

0302 = Laboratory — immunology

0303 = Laboratory — renal patient (home)

0304 = Laboratory — non-routine dialysis

0305 = Laboratory — hematology

0306 = Laboratory — bacteriology and microbiology

0307 = Laboratory — urology

0308 = Reserved laboratory

0309 = Laboratory — other laboratory

0310 = Laboratory pathological — general classification

0311 = Laboratory pathological — cytology

0312 = Laboratory pathological — histology

0314 = Laboratory pathological — biopsy

0319 = Laboratory pathological — other

0320 = Radiology diagnostic — general classification

0321 = Radiology diagnostic — angiocardiography

0322 = Radiology diagnostic — arthrography

0323 = Radiology diagnostic — arteriography

0324 = Radiology diagnostic — chest X-ray

0327 = Reserved radiology, diagnostic

0329 = Radiology diagnostic — other

0330 = Radiology therapeutic — general classification

0331 = Radiology therapeutic — chemotherapy injected

0332 = Radiology therapeutic — chemotherapy oral

0333 = Radiology therapeutic — radiation therapy

0335 = Radiology therapeutic — chemotherapy IV

0339 = Radiology therapeutic — other

0340 = Nuclear medicine — general classification

0341 = Nuclear medicine — diagnostic

0342 = Nuclear medicine — therapeutic

0343 = Nuclear medicine — diagnostic radiopharmaceuticals

0344 = Nuclear medicine — therapeutic radiopharmaceuticals

0349 = Nuclear medicine — other

0350 = Computed tomographic (CT) scan — general classification

0351 = CT scan — head scan

0352 = CT scan — body scan

0359 = CT scan — other CT scans

0360 = Operating room services — general classification

0361 = Operating room services — minor surgery

0362 = Operating room services — organ transplant, other than kidney

0363 = Reserved operating room services

0367 = Operating room services — kidney transplant

0368 = Reserved operating room services

0369 = Operating room services — other operating room services

0370 = Anesthesia — general classification

0371 = Anesthesia — incident to RAD and subject to the payment limit

0372 = Anesthesia — incident to other diagnostic service and subject to the payment limit

0374 = Anesthesia — acupuncture

0379 = Anesthesia — other anesthesia

0380 = Blood — general classification

0381 = Blood — packed red cells

0382 = Blood — whole blood

0383 = Blood — plasma

0384 = Blood — platelets

0385 = Blood — leukocytes

0386 = Blood — other components

0387 = Blood — other derivatives (cryoprecipitates)

0389 = Blood — other blood

0390 = Blood storage and processing — general classification

0391 = Blood storage and processing — blood administration

0392 = Blood storage and processing — storage and processing

0399 = Blood storage and processing — other

0400 = Other imaging services — general classification

0401 = Other imaging services — diagnostic mammography

0402 = Other imaging services — ultrasound

0403 = Other imaging services — screening mammography

0404 = Other imaging services — positron emission tomography

0405 = Reserved imaging services

0409 = Other imaging services — other

0410 = Respiratory services — general classification

0412 = Respiratory services — inhalation services

0413 = Respiratory services — hyperbaric oxygen therapy

0419 = Respiratory services — other

0420 = Physical therapy — general classification

0421 = Physical therapy — visit charge

0422 = Physical therapy — hourly charge

0423 = Physical therapy — group rate

0424 = Physical therapy — evaluation or re-evaluation

0429 = Physical therapy — other

0430 = Occupational therapy — general classification

0431 = Occupational therapy — visit charge

0432 = Occupational therapy — hourly charge

0433 = Occupational therapy — group rate

0434 = Occupational therapy — evaluation or re-evaluation

0439 = Occupational therapy — other (may include restorative therapy)

0440 = Speech language pathology — general classification

0441 = Speech language pathology — visit charge

0442 = Speech language pathology — hourly charge

0443 = Speech language pathology — group rate

0444 = Speech language pathology — evaluation or re-evaluation

0445 = Reserved speech therapy

0449 = Speech language pathology — other

0450 = Emergency room — general classification

0451 = Emergency room — EMTALA emergency medical screening services

0452 = Emergency room — ER beyond EMTALA screening

0456 = Emergency room — urgent care

0459 = Emergency room — other

0460 = Pulmonary function — general classification

0461 = Reserved pulmonary function

0469 = Pulmonary function — other

0470 = Audiology — general classification

0471 = Audiology — diagnostic

0472 = Audiology — treatment

0479 = Audiology — other

0480 = Cardiology — general classification

0481 = Cardiology — cardiac cath lab

0482 = Cardiology — stress test

0483 = Cardiology — Echocardiology

0489 = Cardiology — other

0490 = Ambulatory surgical care — general classification

0499 = Ambulatory surgical care — other

0500 = Outpatient services — general classification

0509 = Outpatient services — other

0510 = Clinic — general classification

0511 = Clinic — chronic pain center

0512 = Clinic — dental center

0513 = Clinic — psychiatric

0514 = Clinic — OB-GYN

0515 = Clinic — pediatric

0516 = Clinic — urgent care clinic

0517 = Clinic — family practice clinic

0519 = Clinic — other

0520 = Free-standing clinic — general classification

0521 = Free-standing clinic — Clinic visit by a member to RHC/FQHC (eff. 7/1/2006). Prior to 7/1/2006 — Rural Health-Clinic

0522 = Free-standing clinic — Home visit by RHC/FQHC practitioner (eff. 7/1/2006). Prior to 7/1/2006 — Rural Health-Home

0523 = Free-standing clinic — family practice

0524 = Free-standing clinic — visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF. (eff. 7/1/2006)

0525 = Free-standing clinic — visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/2006)

0526 = Free-standing clinic — urgent care (eff. 10/1996)

0527 = Free-standing clinic — RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/2006)

0528 = Free-standing clinic — visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident). (eff. 7/1/2006)

0529 = Free-standing clinic — other

0530 = Osteopathic services — general classification

0531 = Osteopathic services — osteopathic therapy

0539 = Osteopathic services — other

0540 = Ambulance — general classification

0541 = Ambulance — supplies

0542 = Ambulance — medical transport

0543 = Ambulance — heart mobile

0544 = Ambulance — oxygen

0545 = Ambulance — air ambulance

0546 = Ambulance — neo-natal ambulance

0547 = Ambulance — pharmacy

0548 = Ambulance — telephone transmission EKG

0549 = Ambulance — other

0550 = Skilled nursing — general classification

0551 = Skilled nursing — visit charge

0552 = Skilled nursing — hourly charge

0559 = Skilled nursing — other

0560 = Medical social services — general classification

0561 = Medical social services — visit charge

0562 = Medical social services — hourly charges

0569 = Medical social services — other

0570 = Home health aid (home health) — general classification

0571 = Home health aid (home health) — visit charge

0572 = Home health aid (home health) — hourly charge

0579 = Home health aid (home health) — other

0580 = Other visits (home health) — general classification (under HHPPS, not allowed as covered charges)

0581 = Other visits (home health) — visit charge (under HHPPS, not allowed as covered charges)

0582 = Other visits (home health) — hourly charge (under HHPPS, not allowed as covered charges)

0583 = Other visits (home health) — assessments under HHPPS, not allow as covered charges)

0589 = Other visits (home health) — other (under HHPPS, not allowed as covered charges)

0590 = Units of service (home health) — general classification (under HHPPS, not allowed as covered charges)

0599 = Units of service (home health) — other (under HHPPS, not allowed as covered charges)

0600 = Oxygen/Home Health — general classification

0601 = Oxygen/Home Health — stat or port equip/supply or count

0602 = Oxygen/Home Health — stat/equip/under 1 LPM

0603 = Oxygen/Home Health — stat/equip/over 4 LPM

0604 = Oxygen/Home Health — stat/equip/portable add-on

0610 = Magnetic resonance technology (MRT) — general classification

0611 = MRT/MRI — brain (including brainstem)

0612 = MRT/MRI — spinal cord (including spine)

0614 = MRT/MRI — other

0615 = MRT/MRA — Head and Neck

0616 = MRT/MRA — Lower Extremities

0618 = MRT/MRA — other

0619 = MRT/Other MRI

0620 = Reserved (Use 0270 for general classification)

0621 = Medical/surgical supplies — incident to radiology-subject to the payment limit — extension of 027X

0622 = Medical/surgical supplies — incident to other diagnostic service-subject to the payment limit — extension of 027X

0623 = Medical/surgical supplies — surgical dressings — extension of 027X

0624 = Medical/surgical supplies — medical investigational devices and procedures with FDA approved IDE's — extension of 027X

0630 = Reserved

0631 = Drugs requiring specific identification — single drug source

0632 = Drugs requiring specific identification — multiple drug source

0633 = Drugs requiring specific identification — restrictive prescription

0634 = Drugs requiring specific identification — EPO under 10,000 units

0635 = Drugs requiring specific identification — EPO 10,000 units or more

0636 = Drugs requiring specific identification — detailed coding

0637 = Self-administered drugs administered in an emergency situation — not requiring detailed coding

0640 = Home IV therapy — general classification

0641 = Home IV therapy — nonroutine nursing

0642 = Home IV therapy — IV site care, central line

0643 = Home IV therapy — IV start/change peripheral line

0644 = Home IV therapy — nonroutine nursing, peripheral line

0645 = Home IV therapy — train patient/caregiver, central line

0646 = Home IV therapy — train disabled patient, central line

0647 = Home IV therapy — train patient/caregiver, peripheral line

0648 = Home IV therapy — train disabled patient, peripheral line

0649 = Home IV therapy — other IV therapy services

0650 = Hospice services — general classification

0651 = Hospice services — routine home care

0652 = Hospice services — continuous home care-1/2

0655 = Hospice services — inpatient care

0656 = Hospice services — general inpatient care (non-respite)

0657 = Hospice services — physician services

0659 = Hospice services — other

0660 = Respite care (HHA) — general classification

0661 = Respite care (HHA) — hourly charge/skilled nursing

0662 = Respite care (HHA) — hourly charge/home health aide/homemaker

0670 = OP special residence charges — general classification

0671 = OP special residence charges — hospital based

0672 = OP special residence charges — contracted

0679 = OP special residence charges — other special residence charges

0680 = Trauma Response — not used

0681 = Trauma response — Level I Trauma

0682 = Trauma response — Level II Trauma

0683 = Trauma response — Level III Trauma

0684 = Trauma response — Level IV Trauma

0689 = Trauma response — Other trauma response

0690 = Pre-hospice/Palliative Care Services — general (eff. 7/1/2017)

0691 = Pre-hospice/Palliative Care Services — visit (eff. 7/1/2017)

0692 = Pre-hospice/Palliative Care Services — hourly (eff. 7/1/2017)

0693 = Pre-hospice/Palliative Care Services — evaluation (eff. 7/1/2017)

0694 = Pre-hospice/Palliative Care Services — consultation and education (eff. 7/1/2017)

0695 = Pre-hospice/Palliative Care Services — Inpatient (eff. 7/1/2017)

0696 = Pre-hospice/Palliative Care Services — Physician (eff. 7/1/2017)

0699 = Pre-hospice/Palliative Care Services — Other (eff. 7/1/2017)

0700 = Cast room — general classification

0709 = Cast room — other

0710 = Recovery room — general classification

0719 = Recovery room — other

0720 = Labor room/delivery — general classification

0721 = Labor room/delivery — labor

0722 = Labor room/delivery — delivery

0723 = Labor room/delivery — circumcision

0724 = Labor room/delivery — birthing center

0729 = Labor room/delivery — other

0730 = EKG/ECG — general classification

0731 = EKG/ECG — Holter monitor

0732 = EKG/ECG — telemetry

0739 = EKG/ECG — other

0740 = EEG — general classification

0743 = Reserved electroencephalogram (EEG)

0749 = EEG (electroencephalogram) — other

0750 = Gastro-intestinal services — general classification

0751 = Reserved gastrointestinal (GI) services

0759 = Gastro-intestinal services — other

0760 = Treatment or observation room — general classification

0761 = Treatment or observation room — treatment room

0762 = Treatment or observation room — observation room

0769 = Treatment or observation room — other

0770 = Preventative care services — general classification

0771 = Preventative care services — vaccine administration

0779 = Preventative care services — other

0780 = Telemedicine — general classification

0789 = Telemedicine — telemedicine

0790 = Lithotripsy — general classification

0799 = Lithotripsy — other

0800 = Inpatient renal dialysis — general classification

0801 = Inpatient renal dialysis — inpatient hemodialysis

0802 = Inpatient renal dialysis — inpatient peritoneal (non-CAPD)

0803 = Inpatient renal dialysis — inpatient CAPD

0804 = Inpatient renal dialysis — inpatient CCPD

0809 = Inpatient renal dialysis — other inpatient dialysis

0810 = Organ acquisition — general classification

0811 = Organ acquisition — living donor

0812 = Organ acquisition — cadaver donor

0813 = Organ acquisition — unknown donor

0814 = Organ acquisition — unsuccessful organ search-donor bank charges

0815 = Allogeneic Stem Cell Acquisition/Donor Services

0819 = Organ acquisition — other donor

0820 = Hemodialysis OP or home dialysis — general classification

0821 = Hemodialysis OP or home dialysis — hemodialysis-composite or other rate

0822 = Hemodialysis OP or home dialysis — home supplies

0823 = Hemodialysis OP or home dialysis — home equipment

0824 = Hemodialysis OP or home dialysis — maintenance/100%

0825 = Hemodialysis OP or home dialysis — support services

0829 = Hemodialysis OP or home dialysis — other

0830 = Peritoneal dialysis OP or home — general classification

0831 = Peritoneal dialysis OP or home — peritoneal-composite or other rate

0832 = Peritoneal dialysis OP or home — home supplies

0833 = Peritoneal dialysis OP or home — home equipment

0834 = Peritoneal dialysis OP or home — maintenance/100%

0835 = Peritoneal dialysis OP or home — support services

0839 = Peritoneal dialysis OP or home — other

0840 = CAPD outpatient — general classification

0841 = CAPD outpatient — CAPD/composite or other rate

0842 = CAPD outpatient — home supplies

0843 = CAPD outpatient — home equipment

0844 = CAPD outpatient — maintenance/100%

0845 = CAPD outpatient — support services

0849 = CAPD outpatient — other

0850 = CCPD outpatient — general classification

0851 = CCPD outpatient — CCPD/composite or other rate

0852 = CCPD outpatient — home supplies

0853 = CCPD outpatient — home equipment

0854 = CCPD outpatient — maintenance/100%

0855 = CCPD outpatient — support services

0859 = CCPD outpatient — other

0860 = Magnetoencephalography (MEG) — general classification

0861 = Magnetoencephalography (MEG) — MEG

0880 = Miscellaneous dialysis — general classification

0881 = Miscellaneous dialysis — ultrafiltration

0882 = Miscellaneous dialysis — home dialysis aide visit

0889 = Miscellaneous dialysis — other

0890 = Other donor bank — general classification; changed to reserved for national assignment

0891 = Other donor bank — bone; changed to reserved for national assignment

0892 = Other donor bank-organ (other than kidney); changed to reserved for national assignment

0893 = Other donor bank — skin; changed to reserved for national assignment

0899 = Other donor bank — other; changed to reserved for national assignment

0900 = Behavior Health Treatment/Services — general classification (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — general classification

0901 = Behavior Health Treatment/Services — electroshock treatment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — electroshock treatment

0902 = Behavior Health Treatment/Services — milieu therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — milieu therapy

0903 = Behavior Health Treatment/Services — play therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — play therapy

0904 = Behavior Health Treatment/Services — activity therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — activity therapy

0905 = Behavior Health Treatment/Services — intensive outpatient services — psychiatric (eff. 10/2004)

0906 = Behavior Health Treatment/Services — intensive outpatient services — chemical dependency (eff. 10/2004)

0907 = Behavior Health Treatment/Services — community behavioral health program — day treatment (eff. 10/2004)

0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — other

0910 = Behavioral Health Treatment/Services — Reserved for National Assignment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — general classification

0911 = Behavioral Health Treatment/Services — rehabilitation (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — rehabilitation

0912 = Behavioral Health Treatment/Services — partial hospitalization — less intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — less intensive

0913 = Behavioral Health Treatment/Services — partial hospitalization — intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — intensive

0914 = Behavioral Health Treatment/Services — individual therapy (eff. 10/2004) prior to 10/2004 defined as Psychiatric/psychological services — individual therapy

0915 = Behavioral Health Treatment/Services — group therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — group therapy

0916 = Behavioral Health Treatment/Services — family therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — family therapy

0917 = Behavioral Health Treatment/Services — biofeedback (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — biofeedback

0918 = Behavioral Health Treatment/Services — testing (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — testing

0919 = Behavioral Health Treatment/Services — other (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — other

0920 = Other diagnostic services — general classification

0921 = Other diagnostic services — peripheral vascular lab

0922 = Other diagnostic services — electromyelogram

0923 = Other diagnostic services — pap smear

0924 = Other diagnostic services — allergy test

0925 = Other diagnostic services — pregnancy test

0929 = Other diagnostic services — other

0931 = Medical Rehabilitation Day Program — Half Day

0932 = Medical Rehabilitation Day Program — Full Day

0940 = Other therapeutic services — general classification

0941 = Other therapeutic services — recreational therapy

0942 = Other therapeutic services — education/training (include diabetes diet training)

0943 = Other therapeutic services — cardiac rehabilitation

0944 = Other therapeutic services — drug rehabilitation

0945 = Other therapeutic services — alcohol rehabilitation

0946 = Other therapeutic services — routine complex medical equipment

0947 = Other therapeutic services — ancillary complex medical equipment

0948 = Other therapeutic services — pulmonary rehab

0949 = Other therapeutic services — other

0951 = Professional Fees — athletic training (extension of 094X)

0952 = Professional Fees — kinesiotherapy (extension of 094X)

0958 = Reserved other, therapeutic services, extension of 094X

0960 = Professional fees — general classification

0961 = Professional fees — psychiatric

0962 = Professional fees — ophthalmology

0963 = Professional fees — anesthesiologist (MD)

0964 = Professional fees — anesthetist (CRNA)

0969 = Professional fees — other (**NOTE:** 097X is an extension of 096X)

0971 = Professional fees — laboratory

0972 = Professional fees — radiology diagnostic

0973 = Professional fees — radiology therapeutic

0974 = Professional fees — nuclear medicine

0975 = Professional fees — operating room

0976 = Professional fees — respiratory therapy

0977 = Professional fees — physical therapy

0978 = Professional fees — occupational therapy

0979 = Professional fees — speech pathology (**NOTE:** 098X is an extension of 096X and 097X)

0981 = Professional fees — emergency room

0982 = Professional fees — outpatient services

0983 = Professional fees — clinic

0984 = Professional fees — medical social services

0985 = Professional fees — EKG

0986 = Professional fees — EEG

0987 = Professional fees — hospital visit

0988 = Professional fees — consultation

0989 = Professional fees — private duty nurse

0990 = Patient convenience items — general classification

0991 = Patient convenience items — cafeteria/guest tray

0992 = Patient convenience items — private linen service

0993 = Patient convenience items — telephone/telegraph

0994 = Patient convenience items — tv/radio

0995 = Patient convenience items — nonpatient room rentals

0996 = Patient convenience items — late discharge charge

0997 = Patient convenience items — admission kits

0998 = Patient convenience items — beauty shop/barber

0999 = Patient convenience items — other

1000 = Behavioral health Accommodations — general

1001 = Behavioral health Accommodations — residential treatment psychiatric

1002 = Behavioral health Accommodations — residential treatment chemical dependency

2101 = Alternative Therapy Services — Acupuncture

2103 = Alternative Therapy Services — Massage

3101 = Adult Day Care — Medical and Social (hourly)

3103 = Adult Day Care — Medical and Social (daily)

3104 = Adult Day Care —Social (daily)

3109 = Adult Day Care —other

NOTE: Following Revenue Codes reported for NHCMQ (RUGS) demo claims effective 2/96.

9000 = RUGS — no MDS assessment available

9001 = Reduced physical functions — RUGS PA1/ADL index of 4–5

9002 = Reduced physical functions — RUGS PA2/ADL index of 4–5

9003 = Reduced physical functions — RUGS PB1/ADL index of 6–8

9004 = Reduced physical functions — RUGS PB2/ADL index of 6–8

9005 = Reduced physical functions — RUGS PC1/ADL index of 9–10

9006 = Reduced physical functions — RUGS PC2/ADL index of 9–10

9007 = Reduced physical functions — RUGS PD1/ADL index of 11–15

9008 = Reduced physical functions — RUGS PD2/ADL index of 11–15

9009 = Reduced physical functions — RUGS PE1/ADL index of 16–18

9010 = Reduced physical functions — RUGS PE2/ADL index of 16–18

9011 = Behavior only problems — RUGS BA1/ADL index of 4–5

9012 = Behavior only problems — RUGS BA2/ADL index of 4–5

9013 = Behavior only problems — RUGS BB1/ADL index of 6–10

9014 = Behavior only problems — RUGS BB2/ADL index of 6–10

9015 = Impaired cognition — RUGS IA1/ADL index of 4–5

9016 = Impaired cognition — RUGS IA2/ADL index of 4–5

9017 = Impaired cognition — RUGS IB1/ADL index of 6–10

9018 = Impaired cognition — RUGS IB2/ADL index of 6–10

9019 = Clinically complex — RUGS CA1/ADL index of 4–5

9020 = Clinically complex — RUGS CA2/ADL index of 4–5d

9021 = Clinically complex — RUGS CB1/ADL index of 6–10

9022 = Clinically complex — RUGS CB2/ADL index of 6–10d

9023 = Clinically complex — RUGS CC1/ADL index of 11–16

9024 = Clinically complex — RUGS CC2/ADL index of 11–16d

9025 = Clinically complex — RUGS CD1/ADL index of 17–18

9026 = Clinically complex — RUGS CD2/ADL index of 17–18d

9027 = Special care — RUGS SSA/ADL index of 7–13

9028 = Special care — RUGS SSB/ADL index of 14–16

9029 = Special care — RUGS SSC/ADL index of 17-–18

Changes effective for providers entering

RUGS Demo Phase III as of 1/1/1997 or later

9030 = Extensive services — RUGS SE1/1 procedure

9031 = Extensive services — RUGS SE2/2 procedures

9032 = Extensive services — RUGS SE3/3 procedures

9033 = Low rehabilitation — RUGS RLA/ADL index of 4–11

9034 = Low rehabilitation — RUGS RLB/ADL index of 12–18

9035 = Medium rehabilitation — RUGS RMA/ADL index of 4-7

9036 = Medium rehabilitation — RUGS RMB/ADL index of 8–15

9037 = Medium rehabilitation — RUGS RMC/ADL index of 16–18

9038 = High rehabilitation — RUGS RHA/ADL index of 4–7

9039 = High rehabilitation — RUGS RHB/ADL index of 8–11

9040 = High rehabilitation — RUGS RHC/ADL index of 12–14

9041 = High rehabilitation — RUGS RHD/ADL index of 15–18

9042 = Very high rehabilitation — RUGS RVA/ADL index of 4–7

9043 = Very high rehabilitation — RUGS RVB/ADL index of 8–13

9044 = Very high rehabilitation — RUGS RVC/ADL index of 14–18

9019 = Clinically complex — RUGS CA1/ADL index of 11

9020 = Clinically complex — RUGS CA2/ADL index of 11D

9021 = Clinically complex — RUGS CB1/ADL index of 12-16

9022 = Clinically complex — RUGS CB2/ADL index of 12-16D

9023 = Clinically complex — RUGS CC1/ADL index of 17-18

9024 = Clinically complex — RUGS CC2/ADL index of 17-18D

9025 = Special care — RUGS SSA/ADL index of 14

9026 = Special care — RUGS SSB/ADL index of 15–16

9027 = Special care — RUGS SSC/ADL index of 17–18

9028 = Extensive services — RUGS SE1/ADL index 7–18/1 procedure

9029 = Extensive services — RUGS SE2/ADL index 7–18/2 procedures

9030 = Extensive services — RUGS SE3/ADL index 7–18/3 procedures

9031 = Low rehabilitation — RUGS RLA/ADL index of 4–13

9032 = Low rehabilitation — RUGS RLB/ADL index of 14–18

9033 = Low rehabilitation — RUGS RLA/ADL index of 4–11

9034 = Medium rehabilitation — RUGS RMB/ADL index of 8–14

9035 = Medium rehabilitation — RUGS RMC/ADL index of 15–18

9036 = High rehabilitation — RUGS RHA/ADL index of 4–7

9037 = High rehabilitation — RUGS RHB/ADL index of 8–12

9038 = High rehabilitation — RUGS RHC/ADL index of 13–18

9039 = Very High rehabilitation — RUGS RVA/ADL index of 4–8

9040 = Very high rehabilitation-RUGS RVB/ADL index of 9–15

9041 = Very high rehabilitation — RUGS RVC/ADL index of 16

9042 = Very high rehabilitation — RUGS RUA/ADL index of 4–8

9043 = Very high rehabilitation — RUGS RUB/ADL index of 9–15

9044 = Ultra high rehabilitation — RUGS RUC/ADL index of 16–18

COMMENT: —

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REV_CNTR_1ST_ANSI_CD

LABEL: Revenue Center 1st ANSI Code

DESCRIPTION: The first code used to identify the detailed reason an adjustment was made (e.g., reason for denial or reducing payment).

SHORT NAME: REVANSI1

LONG NAME: REV_CNTR_1ST_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: *******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******

**********POSITIONS 1 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 gender.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = The date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 = Claim denied because this injury/illness is covered by the liability carrier.

21 = Claim denied because this injury/illness is the liability of the no-fault carrier.

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer.

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

25 = Payment denied. Your Stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.

29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.

37 = Balance does not exceed deductible amount.

38 = Services not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/pre-certification was requested.

40 = Charges do not meet qualifications for emergency/urgent care.

41 = Discount agreed to in Preferred Provider contract.

42 = Charges exceed our fee schedule or maximum allowable amount.

43 = Gramm-Rudman reduction.

44 = Prompt-pay discount.

45 = Charges exceed your contracted/legislated fee arrangement.

46 = This (these) service(s) is(are) not covered.

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.

48 = This (these) procedure(s) is(are) not covered.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.

51 = These are non-covered services because this a pre-existing condition.

52 = The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/perform the service billed.

53 = Services by an immediate relative or a member of the same household are not covered.

54 = Multiple physicians/assistants are not covered in this case.

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts.

88 = Adjustment amount represents collection against receivable created in prior overpayment.

89 = Professional fees removed from charges.

90 = Ingredient cost adjustment.

91 = Dispensing fee adjustment.

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges.

95 = Benefits adjusted. Plan procedures not followed.

96 = Non-covered charges.

97 = Payment is included in allowance for another service/procedure.

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party.

101 = Predetermination: anticipated payment upon completion of services or claim adjudication.

102 = Major medical adjustment.

103 = Provider promotional discount (i.e. Senior citizen discount).

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

108 = Claim/service reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/Product not approved by the Food and Drug Administration.

115 = Claim/service adjusted as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment.

122 = Psychiatric reduction.

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s).

126 = Deductible — Major Medical.

127 = Coinsurance — Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied — prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed, or time limits not met.

139 = Contracted funding agreement — subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount.

A6 = Prior hospitalization or 30-day transfer requirement not met.

A7 = Presumptive Payment Adjustment.

A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

COMMENT: This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.

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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 1/1/2002 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 gender.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = The date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 = Claim denied because this injury/illness is covered by the liability carrier.

21 = Claim denied because this injury/illness is the liability of the no-fault carrier.

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer.

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

25 = Payment denied. Your Stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.

29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.

37 = Balance does not exceed deductible amount.

38 = Services not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/pre-certification was requested.

40 = Charges do not meet qualifications for emergency/urgent care.

41 = Discount agreed to in Preferred Provider contract.

42 = Charges exceed our fee schedule or maximum allowable amount.

43 = Gramm-Rudman reduction.

44 = Prompt-pay discount.

45 = Charges exceed your contracted/legislated fee arrangement.

46 = This (these) service(s) is(are) not covered.

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.

48 = This (these) procedure(s) is(are) not covered.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.

51 = These are non-covered services because this a pre-existing condition.

52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

53 = Services by an immediate relative or a member of the same household are not covered.

54 = Multiple physicians/assistants are not covered in this case.

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts.

88 = Adjustment amount represents collection against receivable created in prior overpayment.

89 = Professional fees removed from charges.

90 = Ingredient cost adjustment.

91 = Dispensing fee adjustment.

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges.

95 = Benefits adjusted. Plan procedures not followed.

96 = Non-covered charges.

97 = Payment is included in allowance for another service/procedure.

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party.

101 = Predetermination: anticipated payment upon completion of services or claim adjudication.

102 = Major medical adjustment.

103 = Provider promotional discount (i.e. Senior citizen discount).

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

108 = Claim/service reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/Product not approved by the Food and Drug Administration.

115 = Claim/service adjusted as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment.

122 = Psychiatric reduction.

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s).

126 = Deductible — Major Medical.

127 = Coinsurance — Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied — prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed, or time limits not met.

139 = Contracted funding agreement — subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount.

A6 = Prior hospitalization or 30-day transfer requirement not met.

A7 = Presumptive Payment Adjustment.

A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

COMMENT: This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.

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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 gender.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = The date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 = Claim denied because this injury/illness is covered by the liability carrier.

21 = Claim denied because this injury/illness is the liability of the no-fault carrier.

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer.

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

25 = Payment denied. Your Stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.

29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.

37 = Balance does not exceed deductible amount.

38 = Services not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/pre-certification was requested.

40 = Charges do not meet qualifications for emergency/urgent care.

41 = Discount agreed to in Preferred Provider contract.

42 = Charges exceed our fee schedule or maximum allowable amount.

43 = Gramm-Rudman reduction.

44 = Prompt-pay discount.

45 = Charges exceed your contracted/legislated fee arrangement.

46 = This (these) service(s) is(are) not covered.

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.

48 = This (these) procedure(s) is(are) not covered.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.

51 = These are non-covered services because this a pre-existing condition.

52 = The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/perform the service billed.

53 = Services by an immediate relative or a member of the same household are not covered.

54 = Multiple physicians/assistants are not covered in this case.

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts.

88 = Adjustment amount represents collection against receivable created in prior overpayment.

89 = Professional fees removed from charges.

90 = Ingredient cost adjustment.

91 = Dispensing fee adjustment.

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges.

95 = Benefits adjusted. Plan procedures not followed.

96 = Non-covered charges.

97 = Payment is included in allowance for another service/procedure.

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party.

101 = Predetermination: anticipated payment upon completion of services or claim adjudication.

102 = Major medical adjustment.

103 = Provider promotional discount (i.e. Senior citizen discount).

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

108 = Claim/service reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/Product not approved by the Food and Drug Administration.

115 = Claim/service adjusted as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment.

122 = Psychiatric reduction.

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s).

126 = Deductible — Major Medical.

127 = Coinsurance — Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied — prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed, or time limits not met.

139 = Contracted funding agreement — subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount.

A6 = Prior hospitalization or 30-day transfer requirement not met.

A7 = Presumptive Payment Adjustment.

A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

COMMENT: This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.

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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 gender.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = The date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 = Claim denied because this injury/illness is covered by the liability carrier.

21 = Claim denied because this injury/illness is the liability of the no-fault carrier.

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer.

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

25 = Payment denied. Your Stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.

29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.

37 = Balance does not exceed deductible amount.

38 = Services not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/pre-certification was requested.

40 = Charges do not meet qualifications for emergency/urgent care.

41 = Discount agreed to in Preferred Provider contract.

42 = Charges exceed our fee schedule or maximum allowable amount.

43 = Gramm-Rudman reduction.

44 = Prompt-pay discount.

45 = Charges exceed your contracted/legislated fee arrangement.

46 = This (these) service(s) is(are) not covered.

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.

48 = This (these) procedure(s) is(are) not covered.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.

51 = These are non-covered services because this a pre-existing condition.

52 = The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/perform the service billed.

53 = Services by an immediate relative or a member of the same household are not covered.

54 = Multiple physicians/assistants are not covered in this case.

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts.

88 = Adjustment amount represents collection against receivable created in prior overpayment.

89 = Professional fees removed from charges.

90 = Ingredient cost adjustment.

91 = Dispensing fee adjustment.

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

94 = Process in excess of charges.

95 = Benefits adjusted. Plan procedures not followed.

96 = Non-covered charges.

97 = Payment is included in allowance for another service/procedure.

98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party.

101 = Predetermination: anticipated payment upon completion of services or claim adjudication.

102 = Major medical adjustment.

103 = Provider promotional discount (i.e. Senior citizen discount).

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

108 = Claim/service reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/Product not approved by the Food and Drug Administration.

115 = Claim/service adjusted as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment.

122 = Psychiatric reduction.

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount — not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s).

126 = Deductible — Major Medical.

127 = Coinsurance — Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied — prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed, or time limits not met.

139 = Contracted funding agreement — subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount.

A6 = Prior hospitalization or 30-day transfer requirement not met.

A7 = Presumptive Payment Adjustment.

A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

COMMENT: This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.

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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 actually used for payment purposes) appears in this field and the original HIPPS code submitted by the provider remains in the HCPCS_CD field. Otherwise, this variable will always be null or have a value of "00000" for HH revenue center records.

The resource utilization group for the particular revenue center is located in the data field called the APC or HIPPS code variable.

The APC is a four-byte field.

The HIPPS code is a five-byte field (such as 1AFKS).

SHORT NAME: APCHIPPS

LONG NAME: REV_CNTR_APC_HIPPS_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: APC codes 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 1/1/2002 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: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html).

This field is populated for those claims that are required to process through Outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

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REV_CNTR_DDCTBL_COINSRNC_CD

LABEL: Revenue Center Deductible Coinsurance Code

DESCRIPTION: Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

SHORT NAME: REVDEDCD

LONG NAME: REV_CNTR_DDCTBL_COINSRNC_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
0 = Charges are subject to deductible and coinsurance
1 = Charges are not subject to deductible
2 = Charges are not subject to coinsurance
3 = Charges are not subject to deductible or coinsurance
4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:
M = Override code; EGHP (employer group health plan) services involved
N = Override code; non-EGHP services involved
X = Override code: MSP (Medicare is secondary payer) cost avoided

COMMENT: —

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REV_CNTR_DSCNT_IND_CD

LABEL: Revenue Center Discount Indicator Code

DESCRIPTION: This code represents a factor that specifies the amount of any Ambulatory payment classification (APC) discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed.

If there is no discounting the factor will be 1.0.

SHORT NAME: DSCNTIND

LONG NAME: REV_CNTR_DSCNT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: *DISCOUNTING FORMULAS*
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D
6 = TD/U
7 = D(1+D)/U
8 = 2.0/U
D = Discounting fraction (currently 0.5)
U = Number of units
T = Terminated procedure discount (currently 0.5)

COMMENT: This field is populated for those claims that are required to process through Outpatient prospective payment system (PPS or 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 K,S,T,V,X)

2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes)

3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B, C, and Z)

4 = Paid at reasonable cost (status indicator F and L)

5 = Additional payment for drug or biological (status indicator G)

6 = Additional payment for device (status indicator H)

7 = Additional payment for new drug or new biological (status indicator J)

8 = Paid partial hospitalization per diem (status indicator P)

9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services)

*********VALUES PRIOR TO 10/3/2005**********

**********Service Status Indicator**********

********** 1st position **********

A = Services not paid under OPPS

C = Inpatient procedure

E = Non-covered items or services

F = Corneal tissue acquisition

G = Current drug or biological pass-through

H = Device pass-through

J = New drug or new biological pass-through

N = Packaged incidental service

P = Partial hospitalization services

S = Significant procedure not subject to multiple procedure discounting

T = Significant procedure subject to multiple procedure discounting

V = Medical visit to clinic or emergency department

X = Ancillary service

**********Payment Indicator**********

********** 2nd position **********

1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)

2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)

3 = Not paid (service indicators C 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 a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment.

In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

Exception (encounter data only): If plan (e.g., MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.

^ Back to TOC ^

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; uses a different fee schedule (e.g., ambulance, PT, mammography)

B = Non-allowed item or service for OPPS; may be paid under a different bill type (e.g., CORF)

C = Inpatient procedure (not paid under OPPS)

E = Non-allowed item or service (not paid by OPPS or any other Medicare payment system)

E1 = Non-allowed item or service — not paid by Medicare when submitted on outpatient claims (any outpatient bill type)

E2 = Non-allowed item or service for which pricing information and claims data is not available — not paid by Medicare when submitted on outpatient claims (any outpatient bill type)

F = Corneal tissue acquisition, certain CRNA services and Hepatitis B vaccinations

G = Drug/biological pass-through (separate APC includes this pass-through amount)

H = Device pass-through (separate cost-based pass-through payment, not subject to coinsurance)

J = New drug or new biological pass-through

J1 = Primary service and all adjunctive services on the claim (comprehensive APC; effective 01/2015)

J2 = Hospital Part B services that may be paid through a comprehensive APC — Paid under OPPS; Addendum B displays APC assignments when services are separately payable

K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources (paid under OPPS; separate APC payment)

L = Flu/PPV vaccines not paid under OPPS

M = Service not billable to fiscal intermediary [now a MAC] (not paid under OPPS)

N = Packaged incidental service (no separate APC payment)

P = Paid partial hospitalization per diem APC payment

Q1 = Separate payment made; OPPS — APC (effective 2009)

Q2 = No separate payment made; OPPS — APC were packaged into payment for other services (effective 2009)

Q3 = May be paid through a composite APC-based on composite-specific criteria or separately through single code APCs when the criteria are not met (eff. 2009)

Q4 = Conditionally packaged laboratory tests Paid under OPPS or CLFS

R = Blood products; Paid under OPPS; separate APC payment

S = Significant procedure not subject to multiple procedure discounting

T = Significant procedure subject to multiple procedure discounting

U = Brachytherapy

V = Medical visit to clinic or emergency department

W = Invalid HCPCS or invalid revenue code with blank HCPCS (terminated)

X = Ancillary service (terminated)

Y = Non-implantable DME (e.g., therapeutic shoes; not paid under OPPS — bill to DMERC)

Z = Valid revenue with blank HCPCS and no other SI assigned (terminated)

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.

^ Back to TOC ^

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.

^ Back to TOC ^

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 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. 4/1/2003 — 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 = 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 = 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)

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 (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)

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 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. 4/1/2003 — 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 = 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)

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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 = 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)

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 (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)

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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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.

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) digit indicate the type of provider ID that is used (3=EIN and 1=SSN). 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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