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Medicare Part A Institutional File Codebook

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Revision History

Revision Date	Version Number	Description	Author(s)
05/08/2017	1.0	Initial release of Codebook for the Medicare Part A Institutional File.	Kathy Schneider, Chris Alleman

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ACTIONCD

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: CWF

VALUES: 1 = Original debit action (always a 1 for all regular bills)

5 = Force action code 3 (secondary debit adjustment)

8 = Benefits refused

COMMENT: -

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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.

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: CWF

VALUES: -

COMMENT: -

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ADMTG_DGNS_CD

LABEL: Claim Admitting Diagnosis Code

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

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

SHORT NAME: ADMTG_DGNS_CD

LONG NAME: ADMTG_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: -

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 or ICD-10.

SHORT NAME: ADMTG_DGNS_VRSN_CD

LONG NAME: ADMTG_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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APCHIPPS

LABEL: Revenue Center APC or HIPPS Code

DESCRIPTION: This field contains one of two potential pieces of data; the Ambulatory Payment Classification (APC) code or the Health Insurance Prospective Payment System (HIPPS) code, which corresponds with the revenue center line for the claim.

The APC codes are used as the basis for payment for outpatient prospective payment (OPPS) service (e.g., Part B institutional).

Some Part A claim types (e.g., home health and SNF) use resource groupings, which are similar to case-mix groups, as the basis for payment (e.g., HHRG, SNF RUGs). For home health (HH) claims, when the revenue center code (variable called REV_CNTR) is 0023, the HHRG is located in this field and is a HIPPS code. This field is only meaningful for a HH claim when CMS determines the claim should be paid using a different HIPPS code than the one submitted by the provider. When this happens, the revised HIPPS code (the one actually used for payment purposes) appears in this field and the original HIPPS code submitted by the provider remains in the HCPCS_CD field. Otherwise, this variable will always be null or have a value of "00000" for HH revenue center records.

The resource utilization group for the particular revenue center is located in the data field called the APC or HIPPS code variable.

The APC is a four byte field.

The HIPPS code is a five byte field (such as 1AFKS).

SHORT NAME: APCHIPPS

LONG NAME: REV_CNTR_APC_HIPPS_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES: APC codes are shown below; HIPPS codes can be downloaded from the CMS website Prospective Payment Systems page (see: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html>).

0000 = Code used when Payment Method Indicator equals 'N9'

0001 = Photochemotherapy

0002 = Fine needle Biopsy/Aspiration 0003 = Bone Marrow Biopsy/Aspiration

0004 = Level I Needle Biopsy/ Aspiration Except Bone Marrow

0005 = Level II Needle Biopsy /Aspiration Except Bone Marrow

0006 = Level I Incision & Drainage

0007 = Level II Incision & Drainage
0008 = Level III Incision & Drainage
0009 = Nail Procedures
0010 = Level I Destruction of Lesion
0011 = Level II Destruction of Lesion
0012 = Level I Debridement & Destruction
0013 = Level II Debridement & Destruction
0014 = Level III Debridement & Destruction
0015 = Level IV Debridement & Destruction
0016 = Level V Debridement & Destruction
0017 = Level VI Debridement & Destruction
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
0019 = Level I Excision/ Biopsy
0020 = Level II Excision/ Biopsy
0021 = Level III Excision/ Biopsy
0022 = Level IV Excision/ Biopsy
0023 = Exploration Penetrating Wound
0024 = Level I Skin Repair
0025 = Level II Skin Repair
0026 = Level III Skin Repair
0027 = Level IV Skin Repair
0028 = Level I Incision/Excision Breast
0029 = Incision/Excision Breast (obsolete 12/00); Level II Incision/Excision Breast (effective 1/01)
0030 = Breast Reconstruction/Mastectomy
0031 = Hyperbaric Oxygen (obsolete 1/01)
0032 = Placement Transvenous Catheters/Arterial Cutdown
0033 = Partial Hospitalization
0040 = Arthrocentesis & Ligament/Tendon Injection
0041 = Arthroscopy
0042 = Arthroscopically-Aided Procedures
0043 = Closed Treatment Fracture Finger/Toe/Trunk
0044 = Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk
0045 = Bone/Joint Manipulation Under Anesthesia
0046 = Open/Percutaneous Treatment Fracture or Dislocation
0047 = Arthroplasty without Prosthesis
0048 = Arthroplasty with Prosthesis
0049 = Level I Musculoskeletal Procedures Except Hand and Foot
0050 = Level II Musculoskeletal Procedures Except Hand and Foot
0051 = Level III Musculoskeletal Procedures Except Hand and Foot
0052 = Level IV Musculoskeletal Procedures Except Hand and Foot
0053 = Level I Hand Musculoskeletal Procedures
0054 = Level II Hand Musculoskeletal Procedures
0055 = Level I Foot Musculoskeletal Procedures
0056 = Level II Foot Musculoskeletal Procedures
0057 = Bunion Procedures
0058 = Level I Strapping and Cast Application
0059 = Level II Strapping and Cast Application

0060 = Manipulation Therapy
 0070 = Thoracentesis/Lavage Procedures
 0071 = Level I Endoscopy Upper Airway
 0072 = Level II Endoscopy Upper Airway
 0073 = Level III Endoscopy Upper Airway
 0074 = Level IV Endoscopy Upper Airway
 0075 = Level V Endoscopy Upper Airway
 0076 = Endoscopy Lower Airway
 0077 = Level I Pulmonary Treatment
 0078 = Level II Pulmonary Treatment
 0079 = Ventilation Initiation and Management
 0080 = Diagnostic Cardiac Catheterization
 0081 = Non-Coronary Angioplasty or Atherectomy
 0082 = Coronary Atherectomy
 0083 = Coronary Angioplasty
 0084 = Level I Electrophysiologic Evaluation
 0085 = Level II Electrophysiologic Evaluation
 0086 = Ablate Heart Dysrhythm Focus
 0087 = Cardiac Electrophysiologic Recording/Mapping
 0088 = Thrombectomy
 0089 = Level I Implantation/Removal/Revision of Pacemaker, AICD Vascular Device
 (obsolete 12/00); Insertion/Replacement of Permanent Pacemaker and
 Electrodes (eff. 1/01)
 0090 = Level II Implantation/Removal/Revision of Pacemaker AICD Vascular Device
 (obsolete 12/00); Insertion/Replacement of Permanent Pacemaker and Pulse
 Generator
 0091 = Level I Vascular Ligation
 0092 = Level II Vascular Ligation
 0093 = Vascular Repair/Fistula Construction
 0094 = Resuscitation and Cardioversion
 0095 = Cardiac Rehabilitation
 0096 = Non-Invasive Vascular Studies
 0097 = Cardiovascular Stress Test (obsolete 12/00); Cardiac Monitoring for 30 days (eff.
 1/01) 0098 = Injection of Sclerosing Solution
 0099 = Continuous Cardiac Monitoring (obsolete 12/00); Electrocardiograms (eff. 1/01)
 0100 = Stress test and continuous ECG
 0101 = Tilt Table Evaluation
 0102 = Electronic Analysis of Pacemakers/other Devices
 0103 = Miscellaneous Vascular Procedures (eff. 1/01)
 0104 = Transcatheter Placement of Intracoronary Stents (eff. 1/01)
 0105 = Revision/Removal of Pacemakers, AICD or Vascular (eff. 1/01)
 0106 = Insertion/Replacement/Repair of Pacemaker Electrode (eff. 1/01)
 0107 = Insertion of Cardioverter-Defibrillator (eff. 1/01)
 0108 = Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads (eff. 1/01)
 0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant (obsolete
 12/00); Removal of Implanted Devices (eff. 1/01)
 0110 = Transfusion
 0111 = Blood PRODUCT Exchange

0112 = Extracorporeal Photopheresis
 0113 = Excision Lymphatic System
 0114 = Thyroid/Lymphadenectomy Procedures
 0115 = Cannula/Access Device Procedures (eff. 1/01)
 0116 = Chemotherapy Administration by Other Technique Except Infusion
 0117 = Chemotherapy Administration by Infusion Only
 0118 = Chemotherapy Administration by Both Infusion and Other Technique
 0119 = Implantation of Devices (eff. 1/01)
 0120 = Infusion Therapy Except Chemotherapy
 0121 = Level I Tube changes and Repositioning
 0122 = Level II Tube changes and Repositioning
 0123 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant
 0124 = Revision of Implanted Infusion Pump (eff. 1/01)
 0130 = Level I Laparoscopy
 0131 = Level II Laparoscopy
 0132 = Level III Laparoscopy
 0140 = Esophageal Dilatation without Endoscopy
 0141 = Upper GI Procedures
 0142 = Small Intestine Endoscopy
 0143 = Lower GI Endoscopy
 0144 = Diagnostic Anoscopy
 0145 = Therapeutic Anoscopy
 0146 = Level I Sigmoidoscopy
 0147 = Level II Sigmoidoscopy
 0148 = Level I Anal/Rectal Procedure
 0149 = Level II Anal/Rectal Procedure
 0150 = Level III Anal/Rectal Procedure
 0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
 0152 = Percutaneous Biliary Endoscopic Procedures
 0153 = Peritoneal and Abdominal Procedures
 0154 = Hernia/Hydrocele Procedures
 0157 = Colorectal Cancer Screening: Barium Enema (Not subject to National coinsurance)
 0158 = Colorectal Cancer Screening: Colonoscopy Not subject to National coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is lower of the HOPD payment rate or the Ambulatory Surgical Center payment.
 0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy Not subject to National coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is lower of the HOPD payment rate or the Ambulatory Surgical Center payment.
 0160 = Level I Cystourethroscopy and other Genitourinary Procedures
 0161 = Level II Cystourethroscopy and other Genitourinary Procedures
 0162 = Level III Cystourethroscopy and other Genitourinary Procedures
 0163 = Level IV Cystourethroscopy and other Genitourinary Procedures
 0164 = Level I Urinary and Anal Procedures
 0165 = Level II Urinary and Anal Procedures
 0166 = Level I Urethral Procedures
 0167 = Level II Urethral Procedures

0168 = Level III Urethral Procedures
0169 = Lithotripsy
0170 = Dialysis for Other Than ESRD Patients
0180 = Circumcision
0181 = Penile Procedures
0182 = Insertion of Penile Prosthesis
0183 = Testes/Epididymis Procedures
0184 = Prostate Biopsy
0190 = Surgical Hysteroscopy
0191 = Level I Female RePROductive Procedures
0192 = Level II Female RePROductive Procedures
0193 = Level III Female RePROductive Procedures
0194 = Level IV Female RePROductive Procedures
0195 = Level V Female RePROductive Procedures
0196 = Dilatation & Curettage
0197 = Infertility Procedures
0198 = Pregnancy and Neonatal Care Procedures
0199 = Vaginal Delivery
0200 = Therapeutic Abortion
0201 = Spontaneous Abortion
0210 = Spinal Tap
0211 = Level I Nervous System Injections
0212 = Level II Nervous System Injections
0213 = Extended EEG Studies and Sleep Studies
0214 = Electroencephalogram
0215 = Level I Nerve and Muscle Tests
0216 = Level II Nerve and Muscle Tests
0217 = Level III Nerve and Muscle Tests
0220 = Level I Nerve Procedures
0221 = Level II Nerve Procedures
0222 = Implantation of Neurological Device
0223 = Level I Revision/Removal Neurological Device (obsolete 12/00); Implantation of Pain Management Device (eff. 1/01)
0224 = Level II Revision/Removal Neurological Device (obsolete 12/00); Implantation of Reservoir/Pump/Shunt (eff. 1/01)
0225 = Implantation of Neurostimulator Electrodes
0226 = Implantation of Drug Infusion Reservoir (eff. 1/01)
0227 = Implantation of Drug Infusion Device (eff. 1/01)
0228 = Creation of Lumbar Subarachnoid Shunt (eff. 1/01)
0229 = Transcatheter Placement of Intravascular Shunts (eff. 1/01)
0230 = Level I Eye Tests
0231 = Level II Eye Tests
0232 = Level I Anterior Segment Eye
0233 = Level II Anterior Segment Eye
0234 = Level III Anterior Segment Eye Procedures
0235 = Level I Posterior Segment Eye Procedures
0236 = Level II Posterior Segment Eye Procedures
0237 = Level III Posterior Segment Eye Procedures

0238 = Level I Repair and Plastic Eye Procedures
0239 = Level II Repair and Plastic Eye Procedures
0240 = Level III Repair and Plastic Eye Procedures
0241 = Level IV Repair and Plastic Eye Procedures
0242 = Level V Repair and Plastic Eye Procedures
0243 = Strabismus/Muscle Procedures
0244 = Corneal Transplant
0245 = Cataract Procedures without IOL Insert
0246 = Cataract Procedures with IOL Insert
0247 = Laser Eye Procedures Except Retinal
0248 = Laser Retinal Procedures
0250 = Nasal Cauterization/Packing
0251 = Level I ENT Procedures
0252 = Level II ENT Procedures
0253 = Level III ENT Procedures
0254 = Level IV ENT Procedures
0256 = Level V ENT Procedures
0257 = Implantation of Cochlear Device (obsolete 1/01)
0258 = Tonsil and Adenoid Procedures
0260 = Level I Plain Film Except Teeth
0261 = Level II Plain Film Except Teeth Including Bone Density Measurement
0262 = Plain Film of Teeth
0263 = Level I Miscellaneous Radiology Procedures
0264 = Level II Miscellaneous Radiology Procedures
0265 = Level I Diagnostic Ultrasound Except Vascular
0266 = Level II Diagnostic Ultrasound Except Vascular
0267 = Vascular Ultrasound
0268 = Guidance Under Ultrasound
0269 = Echocardiogram Except Transesophageal
0270 = Transesophageal Echocardiogram
0271 = Mammography
0272 = Level I Fluoroscopy
0273 = Level II Fluoroscopy
0274 = Myelography
0275 = Arthrography
0276 = Level I Digestive Radiology
0277 = Level II Digestive Radiology
0278 = Diagnostic Urography
0279 = Level I Diagnostic Angiography and Venography Except Extremity
0280 = Level II Diagnostic Angiography and Venography Except Extremity
0281 = Venography of Extremity
0282 = Level I Computerized Axial Tomography
0283 = Level II Computerized Axial Tomography
0284 = Magnetic Resonance Imaging
0285 = Positron Emission Tomography (PET)
0286 = Myocardial Scans
0290 = Standard Non-Imaging Nuclear Medicine
0291 = Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans

0292 = Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans

0294 = Level I Therapeutic Nuclear Medicine

0295 = Level II Therapeutic Nuclear Medicine

0296 = Level I Therapeutic Radiologic Procedures

0297 = Level II Therapeutic Radiologic Procedures

0300 = Level I Radiation Therapy

0301 = Level II Radiation Therapy

0302 = Level III Radiation Therapy

0303 = Treatment Device Construction

0304 = Level I Therapeutic Radiation Treatment Preparation

0305 = Level II Therapeutic Radiation Treatment Preparation

0310 = Level III Therapeutic Radiation Treatment Preparation

0311 = Radiation Physics Services

0312 = Radioelement Applications

0313 = Brachytherapy

0314 = Hyperthermic Therapies

0320 = Electroconvulsive Therapy

0321 = Biofeedback and Other Training

0322 = Brief Individual Psychotherapy

0323 = Extended Individual Psychotherapy

0324 = Family Psychotherapy

0325 = Group Psychotherapy

0330 = Dental Procedures

0340 = Minor Ancillary Procedures

0341 = Immunology Tests

0342 = Level I Pathology

0343 = Level II Pathology

0344 = Level III Pathology

0345 = Transfusion Laboratory Procedures Level I (eff. 1/01)

0346 = Transfusion Laboratory Procedures Level II (eff. 1/01)

0347 = Transfusion Laboratory Procedures Level III (eff. 1/01)

0348 = Fertility Laboratory Procedures (eff. 1/01)

0349 = Miscellaneous Laboratory Procedures (eff. 1/01)

0354 = Administration of Influenza Vaccine (Not subject to national coinsurance)

0355 = Level I Immunizations

0356 = Level II Immunizations

0357 = Level III Immunizations (obsolete 1/01)

0358 = Level IV Immunizations (obsolete 1/01)

0359 = Injections

0360 = Level I Alimentary Tests

0361 = Level II Alimentary Tests

0362 = Fitting of Vision Aids

0363 = Otorhinolaryngologic Function Tests

0364 = Level I Audiometry

0365 = Level II Audiometry

0366 = Electrocardiogram (ECG) (obsolete 1/01)

0367 = Level I Pulmonary Test

0368 = Level II Pulmonary Test

0369 = Level III Pulmonary Test
 0370 = Allergy Tests
 0371 = Allergy Injections
 0372 = Therapeutic Phlebotomy
 0373 = Neuropsychological Testing
 0374 = Monitoring Psychiatric Drugs
 0600 = Low Level Clinic Visits
 0601 = Mid Level Clinic Visits
 0602 = High Level Clinic Visits
 0603 = Interdisciplinary Team Conference (obsolete 1/01)
 0610 = Low Level Emergency Visits
 0611 = Mid Level Emergency Visits
 0612 = High Level Emergency Visits
 0620 = Critical Care
 0701 = Strontium (eligible for pass-through payments) (obsolete 12/00); SR 89 chloride,
 per mCi (eff. 1/01)
 0702 = Samarium (eligible for pass-through payments) (obsolete 12/00); SM 153
 lexidronam, 50 mCi (eff. 1/01)
 0704 = IN 111 Satumomab Pendetide (eligible for pass-through payments)
 0705 = Tc99 Tetrofosmin (eligible for pass-through payments)
 0725 = Leucovorin Calcium (eligible for pass-through payments)
 0726 = Dexrazoxane Hydrochloride (eligible for pass-through payments)
 0727 = Injection, Etidronate Disodium (eligible for pass-through payments)
 0728 = Filgrastim (G-CSF) (eligible for pass-through payments)
 0730 = Pamidronate Disodium (eligible for pass-through payments)
 0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)
 0732 = Mesna (eligible for pass-through payments)
 0733 = Non-ESRD Epoetin Alpha (eligible for pass-through payments)
 0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)
 0754 = Metoclopramide HCL (eligible for pass-through payments)
 0755 = Thiethylperazine Maleate (eligible for pass-through payments)
 0761 = Oral Substitute for IV Antiemetic (eligible for pass-through payments)
 0762 = Dronabinol (eligible for pass-through payments)
 0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)
 0764 = Granisetron HCL, 100 mcg (eligible for pass-through payments)
 0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)
 0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through
 payments)
 0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)
 0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)
 0801 = Cyclophosphamide (eligible for pass-through payments)
 0802 = Etoposide (eligible for pass-through payments)
 0803 = Melphalan (eligible for pass-through payments)
 0807 = Aldesleukin single use vial (eligible for pass-through payments)
 0809 = BCG (Intravesical) one vial (eligible for pass-through payments)
 0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)
 0811 = Carboplatin 50 mg (eligible for pass-through payments)
 0812 = Carmustine 100 mg (eligible for pass-through payments)
 0813 = Cisplatin 10 mg (eligible for pass-through payments)

0814 = Asparaginase, 10,000 units (eligible for pass-through payments)
0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)
0817 = Cytrabine 100 mg (eligible for pass-through payments)
0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)
0819 = Dacarbazine 100 mg (eligible for pass-through payments)
0820 = Daunorubicin HCl 10 mg (eligible for pass-through payments)
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)
0822 = Diethylstilbestrol Diphosphate 250 mg (eligible for pass-through payments)
0823 = Docetaxel 20 mg (eligible for pass-through payments)
0824 = Etoposide 10 mg (eligible for pass-through payments)
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)
0827 = Floxuridine injection 500mg
0828 = Gemcitabine HCL 200 mg (eligible for pass-through payments)
0830 = Irinotecan 20 mg (eligible for pass-through payments)
0831 = Ifosfamide injection 1 gm (eligible for pass-through payments)
0832 = Idarubicin HCL injection 5 mg (eligible for pass-through payments)
0833 = Interferon Alfacon-1, 1 mcg (eligible for pass-through payments)
0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)
0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)
0838 = Interferon, Gamma 1-B injection, 3 million units (eligible for pass-through payments)
0839 = Mechlorethamine HCL injection 10 mg (eligible for pass-through payments)
0840 = Melphalan HCL 50 mg (eligible for pass-through payments)
0841 = Methotrexate sodium injection 5 mg (eligible for pass-through payments)
0842 = Fludarabine Phosphate injection 50 mg (eligible for pass-through payments)
0843 = Pegaspargase, single dose vial (eligible for pass-through payments)
0844 = Pentostatin injection, 10 mg (eligible for pass-through payments)
0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)
0849 = Rituximab, 100 mg (eligible for pass-through payments)
0850 = Streptozocin injection, 1 gm (eligible for pass-through payments)
0851 = Thiotepa injection, 15 mg (eligible for pass-through payments)
0852 = Topotecan 4 mg (eligible for pass-through payments)
0853 = Vinblastine Sulfate injection, 1 mg (eligible for pass-through payments)
0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments)
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)
0856 = Porfimer Sodium 75 mg (eligible for pass-through payments)
0857 = Bleomycin Sulfate injection 15 units (eligible for pass-through payments)
0858 = Cladribine, 1mg (eligible for pass-through payments)
0859 = Fluorouracil injection 500 mg
0860 = Plicamycin (mithramycin) injection, 2.5 mg
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)
0862 = Mitomycin, 5mg (eligible for pass-through payments)
0863 = Paclitaxel, 30mg (eligible for pass-through payments)
0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments)

0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)
0884 = Rho (D) Immune Globulin, Human one dose pack (eligible for pass-through payments)
0886 = Azathioprine, 50 mg oral (Not subject to national coinsurance)
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection (Not subject to national coinsurance)
0888 = Cyclosporine, Oral 100 mg (Not subject to national coinsurance)
0889 = Cyclosporine, Parenteral (Not subject to national coinsurance)
0890 = Lymphocyte Immune Globulin 250 mg (Not subject to national coinsurance)
0891 = Tacrolimus per 1 mg oral (Not subject to national coinsurance)
0892 = Daclizumab, Parenteral, 25 mg (obsolete 1/01) (eligible for pass-through payments)
0900 = Injection, Alglucerase per 10 units (eligible for pass-through payments)
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg (eligible for pass-through payments)
0902 = Botulinum Toxin, Type A per unit (eligible for pass-through payments)
0903 = CMV Immune Globulin (obsolete 12/00); Cytomegalovirus imm IV, vial (eligible for pass-through payments) (eff. 1/01)
0905 = Immune Globulin per 500 mg (eligible for pass-through payments)
0906 = RSV-ivig 50 mg (eligible for pass-through payments)
0907 = Ganciclovir Sodium 500 mg injection (Not subject to national coinsurance)
0908 = Tetanus Immune Globulin, injection up to 250 units (Not subject to national coinsurance)
0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)
0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)
0911 = Streptokinase per 250,000 iu (Not subject to national coinsurance)
0913 = Ganciclovir long act implant 4.5 mg (eligible for pass-through payments)
0914 = Reteplase, 37.6 mg (Not subject to national coinsurance)
0915 = Alteplase injection, recombinant, 10mg (Not subject to national coinsurance)
0916 = Imiglucerase per unit (eligible for pass-through payments)
0917 = Dipyridamole, 10mg / Adenosine 6MG (Not subject to national coinsurance) (obsolete 1/01) Pharmalogic stresses (eff. 1/01)
0918 = Brachytherapy Seeds, Any type, Each (eligible for pass-through payments) (obsolete 4/01)
0925 = Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)
0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)
0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)
0928 = Factor IX, Complex (eligible for pass-through payments)
0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments) (obsolete 1/01) Anti-inhibitor per iu (eff. 1/01)
0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)
0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)
0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)

0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)

0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)

0952 = Cryoprecipitate (not subject to national coinsurance)

0953 = Fibrinogen Unit (not subject to national coinsurance)

0954 = Leukocyte Poor Blood (not subject to national coinsurance)

0955 = Plasma, Fresh Frozen (not subject to national coinsurance)

0956 = Plasma Protein Fraction (not subject to national coinsurance)

0957 = Platelet Concentrate (not subject to national coinsurance)

0958 = Platelet Rich Plasma (not subject to national coinsurance)

0959 = Red Blood Cells (not subject to national coinsurance)

0960 = Washed Red Blood Cells (not subject to national coinsurance)

0961 = Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)

0962 = Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)

0970 = New Technology - Level I (\$0 - \$50) (not subject to national coinsurance)

0971 = New Technology - Level II (\$50 - \$100) (not subject to national coinsurance)

0972 = New Technology - Level III (\$100 - \$200) (not subject to national coinsurance)

0973 = New Technology - Level IV (\$200 - \$300) (not subject to national coinsurance)

0974 = New Technology - Level V (\$300 - \$500) (not subject to national coinsurance)

0975 = New Technology - Level VI (\$500 - \$750) (not subject to national coinsurance)

0976 = New Technology - Level VII (\$750 - \$1000) (not subject to national coinsurance)

0977 = New Technology - Level VIII (\$1000 - \$1250) (not subject to national coinsurance)

0978 = New Technology - Level IX (\$1250 - \$1500) (not subject to national coinsurance)

0979 = New Technology - Level X (\$1500 - \$1750) (not subject to national coinsurance)

0980 = New Technology - Level XI (\$1750 - \$2000) (not subject to national coinsurance)

0981 = New Technology - Level XII (\$2000 - \$2500) (not subject to national coinsurance)

0982 = New Technology - Level XIII (\$2500 - \$3500) (not subject to national coinsurance)

0983 = New Technology - Level XIV (\$3500 - \$5000) (not subject to national coinsurance)

0984 = New Technology - Level XV (\$5000 - \$6000) (not subject to national coinsurance)

0987 = New Device Technology - Level I (\$0 - \$250) (eff. 1/01)

0988 = New Device Technology - Level II (\$250 - \$500) (eff. 1/01)

0989 = New Device Technology - Level III (\$500 - \$750) (eff. 1/01)

0990 = New Device Technology - Level IV (\$750 - \$1000) (eff. 1/01)

0991 = New Device Technology - Level V (\$1000 - \$1500) (eff. 1/01)

0992 = New Device Technology - Level VI (\$1500 - \$2000) (eff. 1/01)

0993 = New Device Technology - Level VII (\$2000 - \$3000) (eff. 1/01)

0994 = New Device Technology - Level VIII (\$3000 - \$4000) (eff. 1/01)

0995 = New Device Technology - Level IX (\$4000 - \$5000) (eff. 1/01)

0996 = New Device Technology - Level X (\$5000 - \$7000) (eff. 1/01)

0997 = New Device Technology - Level XI (\$7000 - \$9000) (eff. 1/01)

1000 = Perclose Closer Prostar Arterial Vascular Closure (eff. 1/01)

1001 = AcuNav-diagnostic ultrasound ca (eff. 1/01)

1002 = Cochlear Implant System (eff. 1/01)

1003 = Cath, ablation, livewire TC (eff. 1/01)

1004 = Fast-Cath, Swartz, SAFL, CSTA (eff. 1/01)

1006 = ARRAY post chamb IOL (eff. 1/01)

1007 = Ams 700 penile prosthesis (eff. 1/01)

1008 = Urolume-implant urethral stent (eff. 1/01)

1009 = Plasma, cryoprecipitate-reduced, unit (eff. 1/01)
 1010 = Blood, L/R CMV-neg (eff. 1/01)
 1011 = Platelets, L/R, CMV-neg (eff. 1/01)
 1012 = Platelet concentrate, L/R, irradiated, unit (eff. 1/01)
 1013 = Platelet concentrate, L/R, unit (eff. 1/01)
 1014 = Platelets, aph/pher, L/R, unit (eff. 1/01)
 1016 = Blood, L/R, froz/deglycerol/washed (eff. 1/01)
 1017 = Platelets, aph/pher, L/R CMV-neg, unit (eff. 1/01)
 1018 = Blood, L/R, irradiated (eff. 1/01)
 1019 = Platelets, aph/pher, L/R, irradiated, unit (eff. 1/01)
 1024 = Quinupristin 150 mg/dalfopriston 350 mg (eff. 1/01)
 1025 = Marinr CS catheter (eff. 1/01)
 1026 = RF Perfrmr cath 5F RF Marinr (eff. 1/01)
 1027 = Magic x/short, radius 14m (eff. 1/01)
 1028 = Prcis Twst trnsvg anch sys (eff. 1/01)
 1029 = CRE guided balloon dil cath (eff. 1/01)
 1030 = Cthtr:Mrshal, Blu Max Utr Dmnd (eff. 1/01)
 1033 = Sonicath mdl 37-410 (eff. 1/01)
 1034 = SURPASS, Long30 SURPASS-cath (eff. 1/01)
 1035 = Cath, Ultra ICE (eff. 1/01)
 1036 = R port/reservior impl dev (eff. 1/01)
 1037 = Vaxcelchronic dialysis cath (eff. 1/01)
 1038 = UltraCross Imaging Cath (eff. 1/01)
 1039 = Wallstent/RP:Trach (eff. 1/01)
 1040 = Wallstent/RP TIPS -- 20/40/60 (eff. 1/01)
 1042 = Wallstent, UltraFlex: Bil (eff. 1/01)
 1045 = I-131 MIBG (ioben-sulfate) 0.5 mCi (eff. 1/01)
 1047 = Navi-Star, Noga-Star cath (eff. 1/01)
 1048 = NeuroCyberneticPros: gen (eff. 1/01)
 1051 = Oasis Thrombectomy Cath (eff. 1/01)
 1053 = EnSite 3000 catheter (eff. 1/01)
 1054 = Hydrolyser Thromb Cath 6/7F (eff. 1/01)
 1055 = Transesoph 210, 210-S Cath (eff. 1/01)
 1056 = Thermachoice II Cath (eff. 1/01)
 1057 = Micromark Tissue Marker (eff. 1/01)
 1059 = Carticel, auto cult-chndr cyte (eff. 1/01)
 1060 = ACS multi-link tristor stent (eff. 1/01)
 1061 = ACS Viking Guiding cath (eff. 1/01)
 1063 = EndoTak Endurance EZ,RX leads (eff. 1/01)
 1067 = Megalink biliary stent (eff. 1/01)
 1068 = Pulsar DDD pmkr (eff. 1/01)
 1069 = Discovery DR, pmaker
 1071 = Pulsar Max, Pulsar SR pmkr (eff. 1/01)
 1072 = Guidant: blIn dil cath (eff. 1/01)
 1073 = Gynecare Morcellator (eff. 1/01)
 1074 = RX/OTW Viatrac-peri dil cath (eff. 1/01)
 1075 = Guidant: lead (eff. 1/01)
 1076 = Ventak minisc defib (eff. 1/01)
 1077 = Ventak VR Prizm VR, sc defib (eff. 1/01)

1078 = Ventak: Prizm, AVIIIDR defib
1079 = CO 57/58 0.5 mCi (eff. 1/01)
1084 = Denileukin diftitox, 300 mcg (eff. 1/01)
1086 = Temozolomide, 5 mg (eff. 1/01)
1087 = I-123 per uCi capsule (eff. 1/01)
1089 = CO 57, 0.5 mCi (eff. 1/01)
1090 = IN 111 Chloride, per mCi (eff. 1/01)
1091 = IN 111 Oxyquinoline, per 5 mCi (eff. 1/01)
1092 = IN 111 Pentetate, per 1.5 mCi (eff. 1/01)
1094 = TC 99M Albumin aggr, per vial
1095 = TC 99M Depreotide, per vial (eff. 1/01)
1096 = TC 99M Exametazime, per dose (eff. 1/01)
1097 = TC 99M Mebrofenin, per vial (eff. 1/01)
1098 = TC 99M Pentetate, per vial (eff. 1/01)
1099 = TC 99M Pyrophosphate, per vial (eff. 1/01)
1100 = Medtronic AVE GT1 guidewire (eff. 1/01)
1101 = Medtronic AVE, AVE Z2 cath (eff. 1/01)
1102 = Synergy Neurostim Genrtr (eff. 1/01)
1103 = Micro Jewell Defibrillator (eff. 1/01)
1104 = RF ConductorAblative Cath (eff. 1/01)
1105 = Sigman 300VDD pacmkr (eff. 1/01)
1106 = SynergyEZ Pt Progmr (eff. 1/01)
1107 = Torqr, Solist cath (eff. 1/01)
1108 = Reveal Cardiac Recorder (eff. 1/01)
1109 = Implantable anchor: Ethicon (eff. 1/01)
1110 = Stable Mapper, cath electrd (eff. 1/01)
1111 = AneuRx Aort-Uni-Ilicstnt & cath (eff. 1/01)
1112 = AneuRx Stent graft/del cath (eff. 1/01)
1113 = Tlnt Endo Sprng Stnt Grft Sys (eff. 1/01)
1114 = TalntSprgStnt + Graf endo pros (eff. 1/01)
1115 = 5038S, 5038, 5038L pace lead (eff. 1/01)
1116 = CapSureSP pacing lead (eff. 1/01)
1117 = Ancure Endograft Del Sys (eff. 1/01)
1118 = Sigma300DR LegIIDR, pacemkr (eff. 1/01)
1119 = Sprint6932, 6943 defib lead (eff. 1/01)
1120 = Sprint6942, 6945 defi lead (eff. 1/01)
1121 = Gem defibrillator (eff. 1/01)
1122 = TC 99M arcitumomab per dose (eff. 1/01)
1123 = Gem II VR defibrillator (eff. 1/01)
1124 = InterStim Test Stim Kit (eff. 1/01)
1125 = Kappa 400SR, Ttopaz II SR pmkr (eff. 1/01)
1126 = Kappa 700 DR pacemkr (eff. 1/01)
1127 = Kappa 700SR, pmkr sgl chamber (eff. 1/01)
1128 = Kappa 700D, Ruby IID pmkr (eff. 1/01)
1129 = Kappa 700VDD, pacmkr (eff. 1/01)
1130 = Sigma 200D, LGCY IID sc pmkr (eff. 1/01)
1131 = Sigma 200DR pmker (eff. 1/01)
1132 = Sigma 200SR Leg II:sc pac (eff. 1/01)
1133 = Sigma SR, Vita SR, pmaker (eff. 1/01)
1134 = Sigma 300D pmker (eff. 1/01)

1135 = Entity DR 5326L/R, DC, pmkr (eff. 1/01)
1136 = Affinity DR 5330L/R, DC, pmkr (eff. 1/01)
1137 = CardioSEAL implant syst (eff. 1/01)
1143 = AddVent mod 2060BL, VDD (eff. 1/01)
1144 = Afnty SP 5130, Integrity SR, pmkr (eff. 1/01)
1145 = Angio-Seal 6fr, 8fr (eff. 1/01)
1147 = AV Plus DX 1368: lead (eff. 1/01)
1148 = Contour MD sc defib (eff. 1/01)
1149 = Entity DC 5226R-pmker (eff. 1/01)
1151 = Passiveplus DXlead, 10mdls (eff. 1/01)
1152 = LifeSite Access System (eff. 1/01)
1153 = Regency SC+ 2402L pmkr (eff. 1/01)
1154 = SPL:SPOI, 0204- defib lead (eff. 1/01)
1155 = Repliform 8 sq cm (eff. 1/01)
1156 = Tr 1102TrSR+ 2260L, 2264L, 5131 (eff. 1/01)
1157 = Trilogy DCT 23/8L pmkr (eff. 1/01)
1158 = TVL lead SV01, SV02, SV04 (eff. 1/01)
1159 = TVL RV02, RV06, RV07: lead (eff. 1/01)
1160 = TVL-ADX 1559: lead (eff. 1/01)
1161 = Tendril DX, 1338 pacing lead (eff. 1/01)
1162 = TempoDr, TrilogyDR+ DC pmkr (eff. 1/01)
1163 = Tendril SDX, 1488T pacing lead (eff. 1/01)
1164 = Iodine-125 brachytx seed (eff. 1/01)
1166 = Cytarabine liposomal, 10 mg (eff. 1/01)
1167 = Epirubicin hcl, 2 mg (eff. 1/01)
1171 = Autosuture site marker stple (eff. 1/01)
1172 = Spacemaker dissect ballon (eff. 1/01)
1173 = Cor stntS540, S670, o-wire stn (eff. 1/01)
1174 = Bard brachytx needle (eff. 1/01)
1178 = Busulfan IV, 6 mg (eff. 1/01)
1180 = Vigor SR, SC, pmkr (eff. 1/01)
1181 = Meridian SSI, SC pmkr (eff. 1/01)
1182 = Pulsar SSI, SC, pmkr (eff. 1/01)
1183 = Jade IIS, Sigma 300S, SC, pmkr (eff. 1/01)
1184 = Sigma 200S, SC, pmkr (eff. 1/01)
1188 = I 131, per mCi (eff. 1/01)
1200 = TC 99M Sodium Clucoheptonate, per vial (eff. 1/01)
1201 = TC 99M succimer, per vial (eff. 1/01)
1202 = TC 99M Sulfur Colloid, per dose (eff. 1/01)
1203 = Verteporfin for Injection (eff. 1/01)
1205 = TC 99M Disofenin, per vial (eff. 1/01)
1207 = Octreotide acetate depot 1 mg (eff. 1/01)
1302 = SQ01:lead (eff. 1/01)
1303 = CapSure Fix 6940/4068-110, lead (eff. 1/01)
1304 = Sonicath mdl 37-416,-418 (eff. 1/01)
1305 = Apligraf (eff. 1/01)
1306 = NeuroCyberneticsPros: lead (eff. 1/01)
1311 = Trilogy DR + DAO pmkr (eff. 1/01)
1312 = Magic WALLSTENT stent-mini (eff. 1/01)
1313 = Magic medium, radius 31mm (eff. 1/01)

1314 = Magic WALLSTENT stent-Long (eff. 1/01)
1315 = Vigor DR, Meridian DR pmkr (eff. 1/01)
1316 = Meridian DDD pmkr (eff. 1/01)
1317 = Discovery SR, pmkr (eff. 1/01)
1318 = Meridian SR pmkr (eff. 1/01)
1319 = Wallstent/RP Enteral--60mm (eff. 1/01)
1320 = Wallstent/RP Iliac Del Sys (eff. 1/01)
1325 = Pallidium - 103 seed (eff. 1/01)
1326 = Angio-jet rheolytic thromb cath (eff. 1/01)
1328 = ANS Renew NS trnsmtr (eff. 1/01)
1333 = PALMZA Corinthian bill stent (eff. 1/01)
1334 = Crown, Mini-crown,CrossLC (eff. 1/01)
1335 = Mesh, Prolene (eff. 1/01)
1336 = Constant Flow Imp Pump (eff. 1/01)
1337 = IsoMed 8472-20/35/60 (eff. 1/01)
1348 = I 131 per mCi solution (eff. 1/01)
1350 = Prosta/OncoSeed, RAPID strand, I-125 (eff. 1/01)
1351 = CapSure (Fix) pacing lead (eff. 1/01)
1352 = Gem II defib (eff. 1/01)
1353 = Itrel Interstm neurostim + ext (eff. 1/01)
1354 = Kappa 400DR, Diamond II 820 DR (eff. 1/01)
1355 = Kappa 600 DR, Vita DR (eff. 1/01)
1356 = Profile MD V-186HV3 sc defib (eff. 1/01)
1357 = Angstrom MD V-190HV3 sc defib (eff. 1/01)
1358 = Affinity DC 5230R-Pacemaker (eff. 1/01)
1359 = Pulsar, Pulsar Max DR, pmkr (eff. 1/01)
1363 = Gem DR, DC, defib (eff. 1/01)
1364 = Photon DR V-230HV3 DC defib (eff. 1/01)
1365 = Guidewire, Hi-Torque 14/18/35 (eff. 1/01)
1366 = Guidewire, PTCA, Hi-Torque (eff. 1/01)
1367 = Guidewire, Hi-Torque Crosslt (eff. 1/01)
1369 = ANS Renew Stim Sys recvr (eff. 1/01)
1370 = Tension-Free Vaginal Tape (eff. 1/01)
1371 = Symp Nitinol Transhep Bil Sys (eff. 1/01)
1372 = Cordis Nitinol bil Stent (eff. 1/01)
1375 = Stent, coronary, NIR (eff. 1/01)
1376 = ANS Renew Stim Sys lead (eff. 1/01)
1377 = Specify 3988 neuro lead (eff. 1/01)
1378 = InterStim Tx 3080/3886 lead (eff. 1/01)
1379 = Pisces-Quad 3887 lead (eff. 1/01)
1400 = Diphenhydramine hcl 50 mg (eff. 1/01)
1401 = Prochlorperazine maleate 5 mg (eff. 1/01)
1402 = Promethazine hcl 12.5 mg oral (eff. 1/01)
1403 = Chlorpromazine hcl 10mg oral (eff. 1/01)
1404 = Trimethobenzamide hcl 250mg (eff. 1/01)
1405 = Thiethylperazine maleate 10 mg (eff. 1/01)
1406 = Perphenazine 4 mg oral (eff. 1/01)
1407 = Hydroxyzine pamoate 25 mg (eff. 1/01)
1409 = Factor via recombinant, per 1.2 mg (eff. 1/01)
1410 = ProSORBA column (eff. 1/01)

1411 = Herculink, OTW SDS bil stent (eff. 1/01)
 1420 = StapleTac2 Bone w/Dermis (eff. 1/01)
 1421 = StapleTac2 Bone w/o Dermis (eff. 1/01)
 1450 = Orthosphere Arthroplasty (eff. 1/01)
 1451 = Orthosphere Arthroplasty Kity (eff. 1/01)
 1500 = Atherectomy sys, peripheral (eff. 1/01)
 1600 = TC 99M sestamibi, per syringe (eff. 1/01)
 1601 = TC 99M medronate, per dose (eff. 1/01)
 1602 = TC 99M apcitide, per vial (eff. 1/01)
 1603 = TL 201, mCi (eff. 1/01)
 1604 = IN 111 capromab pendetide, per dose (eff. 1/01)
 1605 = Abciximab injection, 10 mg (eff. 1/01)
 1606 = Anistreplase, 30 u (eff. 1/01)
 1607 = Eptifibatide injection, 5 mg (eff. 1/01)
 1608 = Etanercept injection, 25 mg (eff. 1/01)
 1609 = Rho(D) Immune globulin h, sd 100 iu (eff. 1/01)
 1611 = Hylan G-F 20 injection, 16 mg (eff. 1/01)
 1612 = Daclizumab, parenteral, 25 mg (eff. 1/01)
 1613 = Trastuzumab, 10 mg (eff. 1/01)
 1614 = Valrubicin, 200 mg (eff. 1/01)
 1615 = Basiliximab, 20 mg (eff. 1/01)
 1616 = Histrelin Acetate, 0.5 mg (eff. 1/01)
 1617 = Lepirdin, 50 mg (eff. 1/01)
 1618 = Von Willebrand factor, per iu (eff. 1/01)
 1619 = Ga 67, per mCi (eff. 1/01)
 1620 = TC 99M Bicisate, per vial (eff. 1/01)
 1621 = Xe 133, per mCi (eff. 1/01)
 1622 = TC 99M Mertiatide, per vial (eff. 1/01)
 1623 = TC 99M Gluceptate (eff. 1/01)
 1624 = P32 sodium, per mCi (eff. 1/01)
 1625 = IN 111 Pentetreotide, per mCi (eff. 1/01)
 1626 = TC 99M Oxidronate, per vial (eff. 1/01)
 1627 = TC-99 labeled red blood cell, per test (eff. 1/01)
 1628 = P32 phosphate chromic, per mCi (eff. 1/01)
 1700 = Authen Mick TP brachy needle (eff. 1/01) (obsolete 4/01)
 1701 = Medtec MT-BT-5201-25 ndl (eff. 1/01) (obsolete 4/01)
 1702 = WWMT brachytx needle (eff. 1/01) (obsolete 4/01)
 1703 = Mentor Prostate Brachy (eff. 1/01) (obsolete 4/01)
 1704 = MT-BT-5001-25/5051-25 (eff. 1/01) (obsolete 4/01)
 1705 = Best Flexi Brachy Needle (eff. 1/01) (obsolete 4/01)
 1706 = Indigo Prostate Seeding Ndl (eff. 1/01) (obsolete 4/01)
 1707 = Varisource Implt Ndl (eff. 1/01) (obsolete 4/01)
 1708 = UroMed Prostate Seed Ndl (eff. 1/01) (obsolete 4/01)
 1709 = Remington Brachytx Needle (eff. 1/01) (obsolete 4/01)
 1710 = US Biopsy Prostate Needle (eff. 1/01) (obsolete 4/01)
 1711 = MD Tech brachytx needle (eff. 1/01) (obsolete 4/01)
 1712 = Imagyn brachytx needle (eff. 1/01) (obsolete 4/01)
 1713 = Anchor/screw bn/bn,tis/bn (eff. 4/01)
 1714 = Cath, trans atherectomy, dir (eff. 4/01)
 1715 = Brachytherapy needle (eff. 4/01)

1716 = Brachytx seed, Gold 198 (eff. 4/01)
1717 = Brachytx seed, HDR Ir-192 (eff. 4/01)
1718 = Brachytx seed, Iodine 125 (eff. 4/01)
1719 = Brachytx seed, Non-HDR Ir-192 (eff. 4/01)
1720 = Brachytx, Palladium 103 (eff. 4/01)
1721 = AICD, dual chamber (eff. 4/01)
1722 = AICD, single chamber (eff. 4/01)
1723 = Cath, ablation, non-cardiac (eff. 4/01)
1724 = Cath, trans atherec, rotation (eff. 4/01)
1725 = Cath, translumin non-laser (eff. 4/01)
1726 = Cath, bal dil, non-vascular (eff. 4/01)
1727 = Cath, bal tis, dis, nonvas (eff. 4/01)
1728 = Cath, brachytx seed adm (eff. 4/01)
1729 = Cath, drainage, biliary (eff. 4/01)
1730 = Cath, EP, 19 or fewer elect (eff. 4/01)
1731 = Cath, EP, 20 or more elect (eff. 4/01)
1732 = Cath, EP, diag/abl, 3D/vect (eff. 4/01)
1733 = Cath, EP, other than temp (eff. 4/01)
1750 = Cath, hemodialysis, long-term (eff. 4/01)
1751 = Cath, inf pr/cent/midline (eff. 4/01)
1752 = Cath, hemodialysis, short-term (eff. 4/01)
1753 = Cath, intravas ultrasound (eff. 4/01)
1754 = Catheter, intradiscal (eff. 4/01)
1755 = Catheter, intraspinal (eff. 4/01)
1756 = Cath, pacing, transesoph (eff. 4/01)
1757 = Cath, thrombectomy/embolect (eff. 4/01)
1758 = Cath, ureteral (eff. 4/01)
1759 = Cath, intra echocardiography (eff. 4/01)
1760 = Closure dev, vasc, imp/insert (eff. 4/01)
1762 = Conn tiss, human (inc fascia) (eff. 4/01)
1763 = Conn tiss, non-human (eff. 4/01)
1764 = Event recorder, cardiac (eff. 4/01)
1767 = Generator, neurostim, imp (eff. 4/01)
1768 = Graft, vascular (eff. 4/01)
1769 = Guide wire (eff. 4/01)
1770 = Imaging coil, MR insertable (eff. 4/01)
1771 = Rep dev, urinary, w/sling (eff. 4/01)
1772 = Infusion pump, programmable (eff. 4/01)
1773 = Retrieval dev, insert (eff. 4/01)
1776 = Joint device (implantable) (eff. 4/01)
1777 = Lead, AICD, endo single coil (eff. 4/01)
1778 = Lead, neurostimulator (eff. 4/01)
1779 = Lead, pmkr, transvenous VDD (eff. 4/01)
1780 = Lens, intraocular (eff. 4/01)
1781 = Mesh (implantable) (eff. 4/01)
1782 = Morcellator (eff. 4/01)
1784 = Ocular dev, intraop, det ret (eff. 4/01)
1785 = Pmkr, dual, rate-resp (eff. 4/01)
1786 = Pmkr, single, rate-resp (eff. 4/01)
1787 = Patient progr, neurostim (eff. 4/01)

1788 = Port, indwelling, imp (eff. 4/01)
1789 = Prosthesis, breast, imp. (eff. 4/01)
1790 = Iridium 192 HDR (eff. 1/01) (obsolete 4/01)
1791 = OncoSeed, Rapid Strand I-125 (eff. 1/01) (obsolete 4/01)
1792 = UroMed I-125 Brachy seed (eff. 1/01) (obsolete 4/01)
1793 = Bard InterSource P-103 seed (eff. 1/01) (obsolete 4/01)
1794 = Bard IsoSeed P-103 seed (eff. 1/01) (obsolete 4/01)
1795 = Bard BrachySource I-125 (eff. 1/01) (obsolete 4/01)
1796 = Source Tech Med I-125 (eff. 1/01) (obsolete 4/01)
1797 = Draximage I-125 seed (eff. 1/01) (obsolete 4/01)
1798 = Syncor I-125 PharmaSeed (eff. 1/01) (obsolete 4/01)
1799 = I-Plant I-125 Brachytx seed (eff. 1/01) (obsolete 4/01)
1800 = Pd-103 brachytx seed (eff. 1/01) (obsolete 4/01)
1801 = IoGold I-125 brachytx seed (eff. 1/01) (obsolete 4/01)
1802 = Iridium 192 brachytx seed (eff. 1/01) (obsolete 4/01)
1803 = Best Iodine 125 brachytx seeds (eff. 1/01) (obsolete 4/01)
1804 = Best Palladium 103 seeds (eff. 1/01) (obsolete 4/01)
1805 = IsoStar Iodine-125 seeds (eff. 1/01) (obsolete 4/01)
1806 = Gold 198 (eff. 1/01) (obsolete 4/01)
1810 = D114S Dilatation Cath (eff. 1/01) (obsolete 4/01)
1811 = Surgical Dynamics Anchors (eff. 1/01) (obsolete 4/01)
1812 = OBL Anchors (eff. 1/01) (obsolete 4/01)
1813 = Prosthesis, penile, inflatab (eff. 4/01)
1815 = Pros, urinary sph, imp (eff. 4/01)
1816 = Receiver/transmitter, neuro (eff. 4/01)
1817 = Septal defect imp sys (eff. 4/01)
1850 = Repliform 14/21 sq cm (eff. 1/01) (obsolete 4/01)
1851 = Repliform 24/28 sq cm (eff. 1/01) (obsolete 4/01)
1852 = TransCyte, per 247 sq cm (eff. 1/01) (obsolete 4/01)
1853 = Suspend, per 8/14 sq cm (eff. 1/01) (obsolete 4/01)
1854 = Suspend, per 24/28 sq cm (eff. 1/01) (obsolete 4/01)
1855 = Suspend, per 36 sq cm (eff. 1/01) (obsolete 4/01)
1856 = Suspend, per 48 sq cm (eff. 1/01) (obsolete 4/01)
1857 = Suspend, per 84 sq cm (eff. 1/01) (obsolete 4/01)
1858 = DuraDerm, per 8/14 sq cm (eff. 1/01) (obsolete 4/01)
1859 = DuraDerm, per 21/24 sq cm (eff. 1/01) (obsolete 4/01)
1860 = DuraDerm, per 48 sq cm (eff. 1/01) (obsolete 4/01)
1861 = DuraDerm, per 36 sq cm (eff. 1/01) (obsolete 4/01)
1862 = DuraDerm, per 72 sq cm (eff. 1/01) (obsolete 4/01)
1863 = DuraDerm, per 84 sq cm (eff. 1/01) (obsolete 4/01)
1864 = SpermaTex, per 13/44 sq cm (eff. 1/01) (obsolete 4/01)
1865 = FasLata, per 8/14 sq cm (eff. 1/01) (obsolete 4/01)
1866 = FasLata, per 24/28 sq cm (eff. 1/01) (obsolete 4/01)
1867 = FasLata, per 36/48 sq cm (eff. 1/01) (obsolete 4/01)
1868 = FasLata, per 96 sq cm (eff. 1/01) (obsolete 4/01)
1869 = Gore Thyroplasty Dev (eff. 1/01) (obsolete 4/01)
1870 = DermMatrix, per 16 sq cm (eff. 1/01) (obsolete 4/01)
1871 = DermMatrix, 32 or 64 sq cm (eff. 1/01) (obsolete 4/01)
1872 = Dermagraft, per 37.5 sq cm (eff. 1/01) (obsolete 4/01)
1873 = Bard 3DMax Mesh (eff. 1/01) (obsolete 4/01)

1874 = Stent, coated/cov w/del sys (eff. 4/01)
1875 = Stent, coated/cov w/o del sys (eff. 4/01)
1876 = Stent, non-coated/no-cov w/del (eff. 4/01)
1877 = Stent, non-coated/cov w/o del (eff. 4/01)
1878 = Martl for vocal cord (eff. 4/01)
1879 = Tissue marker, imp (eff. 4/01)
1880 = Vena cava filter (eff. 4/01)
1881 = Dialysis access system (eff. 4/01)
1882 = AICD, other than sing/dual (eff. 4/01)
1883 = Adapt/ext, pacing/neuro lead (eff. 4/01)
1885 = Cath, translumin angio laser (eff. 4/01)
1887 = Catheter, guiding (eff. 4/01)
1891 = Infusion pump, non-prog, perm (eff. 4/01)
1892 = Intro/sheath , fixed, peel-away (eff. 4/01)
1893 = Intro/sheath, fixed, non-peel (eff. 4/01)
1894 = Intro/sheath, non-laser (eff. 4/01)
1895 = Lead, AICD, endo dual coil (eff. 4/01)
1896 = Lead, AICD, non sing/dual (eff. 4/01)
1897 = Lead, neurostim test kit (eff. 4/01)
1898 = Lead, pmkr, other than trans (eff. 4/01)
1899 = Lead, pmkr/AICD combination (eff. 4/01)
1929 = Maverick PTCA Cath (eff. 1/01) (obsolete 4/01)
1930 = Coyote Dil Cath, 20/30/40mm (eff. 1/01) (obsolete 4/01)
1931 = Talon Dil Cath (eff. 1/01) (obsolete 4/01)
1932 = Scimed remedy Dil Cath (eff. 1/01) (obsolete 4/01)
1933 = Opti-Plast XL/Centurion Cath (eff. 1/01) (obsolete 4/01)
1934 = Ultraverse 3.5F Bal Dil Cath (eff. 1/01) (obsolete 4/01)
1935 = Workhorse PTA Bal Cath (eff. 1/01) (obsolete 4/01)
1936 = Uromax Ultra Bal Dil Cath (eff. 1/01) (obsolete 4/01)
1937 = Synergy Balloon Dil Cath (eff. 1/01) (obsolete 4/01)
1938 = Uroforce Bal Dil Cath (eff. 1/01) (obsolete 4/01)
1939 = Raptur, Ninja PTCA Dil Cath (eff. 1/01) (obsolete 4/01)
1940 = PowerFlex, OPTA 5/LP Bal Cath (eff. 1/01) (obsolete 4/01)
1941 = Jupiter PTA Dil Cath (eff. 1/01) (obsolete 4/01)
1942 = Cordis Maxi LD PTA Bal Cath (eff. 1/01) (obsolete 4/01)
1943 = RXCrossSail OTW OpenSail (eff. 1/01) (obsolete 4/01)
1944 = Rapid Exchange Bil Dil Cath (eff. 1/01) (obsolete 4/01)
1945 = Savvy PTA Dil Cath (eff. 1/01) (obsolete 4/01)
1946 = R1s Rapid Dil Cath (eff. 1/01) (obsolete 4/01)
1947 = Gazelle Bal Dil Cath (eff. 1/01) (obsolete 4/01)
1948 = Pursuit Balloon Cath (eff. 1/01) (obsolete 4/01)
1949 = Oracle Megasonics Cath (eff. 1/01) (obsolete 4/01)
1979 = Visions PV/Avanar US Cath (eff. 1/01) (obsolete 4/01)
1980 = Atlantis SR Coronary Cath (eff. 1/01) (obsolete 4/01)
1981 = PTCA Catheters (eff. 1/01) (obsolete 4/01)
2000 = Orbiter ST Steerable Cath (eff. 1/01) (obsolete 4/01)
2001 = Constellation Diag Cath (eff. 1/01) (obsolete 4/01)
2002 = Irvine 5F Inquiry Diag EP Cath (eff. 1/01) (obsolete 4/01)
2003 = Irvine 6F Inquiry Diag EP Cath (eff. 1/01) (obsolete 4/01)
2004 = Biosense EP Cath -- Octapolar (eff. 1/01) (obsolete 4/01)

2005 = Biosense EP Cath -- Hexapolar (eff. 1/01) (obsolete 4/01)
 2006 = Biosense EP Cath -- Decapolar (eff. 1/01) (obsolete 4/01)
 2007 = Irvine 6F Luma-Cath EP Cath (eff. 1/01) (obsolete 4/01)
 2008 = 7F Luma-Cath EP Cath 81910-15 (eff. 1/01) (obsolete 4/01)
 2009 = Irvine 7F Luma-Cath EP Cath (eff. 1/01) (obsolete 4/01)
 2010 = Fixed Curve EP Cath (eff. 1/01) (obsolete 4/01)
 2011 = Deflectable Tip Cath--Quad (eff. 1/01) (obsolete 4/01)
 2012 = Celsius Abln Cath (eff. 1/01) (obsolete 4/01)
 2013 = Celsius Large Abln Cath (eff. 1/01) (obsolete 4/01)
 2014 = Celsius II Asym Abln Cath (eff. 1/01) (obsolete 4/01)
 2015 = Celsius II Sym Abln Cath (eff. 1/01) (obsolete 4/01)
 2016 = Navi-Star DS, Navi-Star Ther (eff. 1/01) (obsolete 4/01)
 2017 = Navi-Star Abln Cath (eff. 1/01) (obsolete 4/01)
 2018 = Polaris T Ablation Cath (eff. 1/01) (obsolete 4/01)
 2019 = EP Deflectable Cath (eff. 1/01) (obsolete 4/01)
 2020 = Blazer II XP Abln Cath (eff. 1/01) (obsolete 4/01)
 2021 = SilverFlex EP Cath (eff. 1/01) (obsolete 4/01)
 2022 = CP Chilli Cooled Abln Cath (eff. 1/01) (obsolete 4/01)
 2023 = Chilli Cld AblnCath-std, lg (eff. 1/01) (obsolete 4/01)
 2100 = CP CS Reference Cath (eff. 1/01) (obsolete 4/01)
 2102 = CP Raddi 7F EP Cath (eff. 1/01) (obsolete 4/01)
 2103 = CP Raddi 7F EP Cath w/Track (eff. 1/01) (obsolete 4/01)
 2104 = Lasso Deflectable Cath (eff. 1/01) (obsolete 4/01)
 2151 = Veripath Guiding Cath (eff. 1/01) (obsolete 4/01)
 2152 = Cordis Vista Brite Tip Cath (eff. 1/01) (obsolete 4/01)
 2153 = Bard Viking Cath (eff. 1/01) (obsolete 4/01)
 2200 = Arrow-Trerotola PTD Cath (eff. 1/01) (obsolete 4/01)
 2300 = Varisource Stnd Catheters (eff. 1/01) (obsolete 4/01)
 2597 = Clinicath/kit 16/18 sgl/dbl (eff. 1/01) (obsolete 4/01)
 2598 = Clinicath 18/20/24-G single (eff. 1/01) (obsolete 4/01)
 2599 = Clinicath 16/18-G-double (eff. 1/01) (obsolete 4/01)
 2601 = Bard DL Ureteral Cath (eff. 1/01) (obsolete 4/01)
 2602 = Vitesse Laser Cath 1.4/1.7mm (eff. 1/01) (obsolete 4/01)
 2603 = Vitesse Laser Cath 2.0mm (eff. 1/01) (obsolete 4/01)
 2604 = Vitesse E Laser Cath 2.0mm (eff. 1/01) (obsolete 4/01)
 2605 = Extreme Laser Catheter (eff. 1/01) (obsolete 4/01)
 2606 = SpineCath XL Catheter (eff. 1/01) (obsolete 4/01)
 2607 = SpineCath Intradiscal Cath (eff. 1/01) (obsolete 4/01)
 2608 = Scimed 6F Wiseguide Cath (eff. 1/01) (obsolete 4/01)
 2609 = Flexima Bil Drainage Cath (eff. 1/01) (obsolete 4/01)
 2610 = FlexTipPlus Intraspinal Cath (eff. 1/01) (obsolete 4/01)
 2611 = AlgoLine Intraspinal Cath (eff. 1/01) (obsolete 4/01)
 2612 = InDura Catheter (eff. 1/01) (obsolete 4/01)
 2615 = Sealant, pulmonary, liquid (eff. 4/01)
 2616 = Brachytx seed, Yttrium-90 (eff. 4/01)
 2617 = Stent, non-cor, tem w/o del (eff. 4/01)
 2618 = Probe, cryoablation (eff. 4/01)
 2619 = Pmkr, dual, non rate-resp (eff. 4/01)
 2620 = Pmkr, single, non rate-resp (eff. 4/01)
 2621 = Pmkr, other than single/dual (eff. 4/01)

2622 = Prosthesis, penile, non-inf (eff. 4/01)
2625 = Stent, non-cor , tem w/del sys (eff. 4/01)
2626 = Infusion pump, non-prog, temp (eff. 4/01)
2627 = Cath, suprapubic/cystoscopic (eff. 4/01)
2628 = Catheter, occlusion (eff. 4/01)
2629 = Intro/sheath, laser (eff. 4/01)
2630 = Cath, EP, temp-controlled (eff. 4/01)
2631 = Rep dev, urinary, w/o sling (eff. 4/01)
2700 = MycroPhylax Plus CS defib (eff. 1/01) (obsolete 4/01)
2701 = Phylax XM SC defib (eff. 1/01) (obsolete 4/01)
2702 = Ventak Prizm 2VR Defib (eff. 1/01) (obsolete 4/01)
2703 = Ventak Prizm VR HE Defib (eff. 1/01) (obsolete 4/01)
2704 = Ventak Mini IV + Defib (eff. 1/01) (obsolete 4/01)
2801 = Defender IV DR 612 DC defib (eff. 1/01) (obsolete 4/01)
2802 = Phylax AV DC defib (eff. 1/01) (obsolete 4/01)
2803 = Ventak Prizm DR HE Defib (eff. 1/01) (obsolete 4/01)
2804 = Ventak Prizm 2 DR Defib (eff. 1/01) (obsolete 4/01)
2805 = Jewel AF 7250 Defib (eff. 1/01) (obsolete 4/01)
2806 = GEM VR 7227 Defib (eff. 1/01) (obsolete 4/01)
2807 = Contak CD 1823 (eff. 1/01) (obsolete 4/01)
2808 = Contak TR 1241 (eff. 1/01) (obsolete 4/01)
3001 = Kainox SL/RV defib lead (eff. 1/01) (obsolete 4/01)
3002 = EasyTrak Defib Lead (eff. 1/01) (obsolete 4/01)
3003 = Endotak SQ Array XP lead (eff. 1/01) (obsolete 4/01)
3004 = Intervene Defib lead (eff. 1/01) (obsolete 4/01)
3400 = Siltex Spectrum, Contour Prof (eff. 1/01) (obsolete 4/01)
3401 = Saline-Filled Spectrum (eff. 1/01) (obsolete 4/01)
3500 = Mentor alpha I Inf Penile Pros (eff. 1/01) (obsolete 4/01)
3510 = AMS 800 Urinary Pros (eff. 1/01) (obsolete 4/01)
3551 = Choice/PT Graphix/Luge/Trooper (eff. 1/01) (obsolete 4/01)
3552 = Hi-Torque Whisper (eff. 1/01) (obsolete 4/01)
3553 = Cordis guidewires (eff. 1/01) (obsolete 4/01)
3554 = Jindo guidewire (eff. 1/01) (obsolete 4/01)
3555 = Wholey Hi-Torque Plus GW (eff. 1/01) (obsolete 4/01)
3556 = Wave/FlowWire Guidewire (eff. 1/01) (obsolete 4/01)
3557 = HyTek guidewire (eff. 1/01) (obsolete 4/01)
3800 = SynchroMed EL infusion pump (eff. 1/01) (obsolete 4/01)
3801 = Arrow/Microject PCAQ Sys (eff. 1/01) (obsolete 4/01)
3851 = Elastic UV IOL AA-4203T/TF/TL (eff. 1/01) (obsolete 4/01)
4000 = Opus G 4621, 4624 SC pmkr (eff. 1/01) (obsolete 4/01)
4001 = Opus S 4121/4124 SC pmkr (eff. 1/01) (obsolete 4/01)
4002 = Talent 113 SC pmkr (eff. 1/01) (obsolete 4/01)
4003 = Kairos SR SC pmkr (eff. 1/01) (obsolete 4/01)
4004 = Actros SR, Actros SLR SC pmkr (eff. 1/01) (obsolete 4/01)
4005 = Philos SR/SR-B SC pmkr (eff. 1/01) (obsolete 4/01)
4006 = Pulsar Max II SR pmkr (eff. 1/01) (obsolete 4/01)
4007 = Marathon SR pmkr (eff. 1/01) (obsolete 4/01)
4008 = Discovery II SSI pmkr (eff. 1/01) (obsolete 4/01)
4009 = Discovery II SR pmkr (eff. 1/01) (obsolete 4/01)
4300 = Integrity AFx DR 5342 pmkr (eff. 1/01) (obsolete 4/01)

4301 = Integrity AFx DR 5346 pmkr (eff. 1/01) (obsolete 4/01)
4302 = Affinity VDR 5430 DR (eff. 1/01) (obsolete 4/01)
4303 = Brio 112 DC pmkr (eff. 1/01) (obsolete 4/01)
4304 = Brio 212, Talent 213/223 DC pmkr (eff. 1/01) (obsolete 4/01)
4305 = Brio 222 DC pmkr (eff. 1/01) (obsolete 4/01)
4306 = Brio 220 DC pmkr (eff. 1/01) (obsolete 4/01)
4307 = Kairos DR DC pmkr (eff. 1/01) (obsolete 4/01)
4308 = Inos2, Inos2+ DC pmkr (eff. 1/01) (obsolete 4/01)
4309 = Actros DR,D,DR-A, SLR DC pmkr (eff. 1/01) (obsolete 4/01)
4310 = Actros DR-B DC pmkr (eff. 1/01) (obsolete 4/01)
4311 = Philos DR/DR-B/SLR DC (eff. 1/01) (obsolete 4/01)
4312 = Pulsar Max II DR pmkr (eff. 1/01) (obsolete 4/01)
4313 = Marathon DR pmkr (eff. 1/01) (obsolete 4/01)
4314 = Momentum DR pmkr (eff. 1/01) (obsolete 4/01)
4315 = Selection AFm pmkr (eff. 1/01) (obsolete 4/01)
4316 = Discovery II DR (eff. 1/01) (obsolete 4/01)
4317 = Discovery II DDD (eff. 1/01) (obsolete 4/01)
4600 = Snynox, Polyrox, Elox, Retrox (eff. 1/01) (obsolete 4/01)
4602 = Tendril SDX, 1488K pmkr lead (eff. 1/01) (obsolete 4/01)
4603 = Oscor/Flexion pmkr lead (eff. 1/01) (obsolete 4/01)
4604 = CrystallineActFix, CapsureFix (eff. 1/01) (obsolete 4/01)
4605 = CapSure Epi pmkr lead (eff. 1/01) (obsolete 4/01)
4606 = Flextend pmkr lead (eff. 1/01) (obsolete 4/01)
4607 = Finelinell/EZ, Thinlinell/EZ (eff. 1/01) (obsolete 4/01)
5000 = BX Velocity w/Hepacoat (eff. 1/01) (obsolete 4/01)
5001 = Memotherm Bil Stent, sm, med (eff. 1/01) (obsolete 4/01)
5002 = Memotherm Bil Stent, large (eff. 1/01) (obsolete 4/01)
5003 = Memotherm Bil Stent, x-large (eff. 1/01) (obsolete 4/01)
5004 = PalmazCorinthian IQ Bil Stent (eff. 1/01) (obsolete 4/01)
5005 = PalmazCorinthian IQ Trans/Bil (eff. 1/01) (obsolete 4/01)
5006 = PalmazTran Bil Stent Sys-Med (eff. 1/01) (obsolete 4/01)
5007 = PalmazTran XL Bil Stent--40mm (eff. 1/01) (obsolete 4/01)
5008 = PalmazTran XL Bil Stent--50mm (eff. 1/01) (obsolete 4/01)
5009 = VistaFlex Biliary Stent (eff. 1/01) (obsolete 4/01)
5010 = Rapid Exchange Bil Stent Sys (eff. 1/01) (obsolete 4/01)
5011 = IntraStent, IntraStent LP (eff. 1/01) (obsolete 4/01)
5012 = IntraStent DoubleStrut LD (eff. 1/01) (obsolete 4/01)
5013 = IntraStent DoubleStrut XS (eff. 1/01) (obsolete 4/01)
5014 = AVE Bridge Stent Sys-10/17/28 (eff. 1/01) (obsolete 4/01)
5015 = AVE/X3 Bridge Sys, 40-100 (eff. 1/01) (obsolete 4/01)
5016 = Biliary stent single use cov (eff. 1/01) (obsolete 4/01)
5017 = WallstentRP Bil--20/40/60/68mm (eff. 1/01) (obsolete 4/01)
5018 = WallstentRP Bil--80/94mm (eff. 1/01) (obsolete 4/01)
5019 = Flexima Bil Stent Sys (eff. 1/01) (obsolete 4/01)
5020 = Smart Nitinol Stent--20mm (eff. 1/01) (obsolete 4/01)
5021 = Smart Nitinol Stent--40/60mm (eff. 1/01) (obsolete 4/01)
5022 = Smart Nitinol Stent--80mm (eff. 1/01) (obsolete 4/01)
5023 = BX Velocity Stent--8/13mm (eff. 1/01) (obsolete 4/01)
5024 = BX Velocity Stent 18mm (eff. 1/01) (obsolete 4/01)
5025 = BX Velocity Stent 23 mm (eff. 1/01) (obsolete 4/01)

5026 = BX Velocity Stent 28/33mm (eff. 1/01) (obsolete 4/01)
5027 = BX Velocity Stent w/Hep--8/13mm (eff. 1/01) (obsolete 4/01)
5028 = BX Velocity Stent w/Hep--18mm (eff. 1/01) (obsolete 4/01)
5029 = BX Velocity Stent w/Hep--23mm (eff. 1/01) (obsolete 4/01)
5030 = Stent, coronary, S660 9/12mm (eff. 1/01) (obsolete 4/01)
5031 = Stent, coronary, S660 15/18mm (eff. 1/01) (obsolete 4/01)
5032 = Stent, coronary, S660 24/30mm (eff. 1/01) (obsolete 4/01)
5033 = Niroyal Stent Sys, 9mm (eff. 1/01) (obsolete 4/01)
5034 = Niroyal Stent Sys, 12/15mm (eff. 1/01) (obsolete 4/01)
5035 = Niroyal Stent Sys, 18mm (eff. 1/01) (obsolete 4/01)
5036 = Niroyal Stent Sys, 25mm (eff. 1/01) (obsolete 4/01)
5037 = Niroyal Stent Sys, 31mm (eff. 1/01) (obsolete 4/01)
5038 = BX Velocity Stent w/Raptor (eff. 1/01) (obsolete 4/01)
5039 = IntraCoil Periph Stent--40mm (eff. 1/01) (obsolete 4/01)
5040 = IntraCoil Periph Stent--60mm (eff. 1/01) (obsolete 4/01)
5041 = BeStent Over-the-Wire 24/30mm (eff. 1/01) (obsolete 4/01)
5042 = BeStent Over-the-Wire 18mm (eff. 1/01) (obsolete 4/01)
5043 = BeStent Over-the-Wire 15mm (eff. 1/01) (obsolete 4/01)
5044 = BeStent Over-the-Wire 9/12mm (eff. 1/01) (obsolete 4/01)
5045 = Multilink Tetra Cor Stent Sys (eff. 1/01) (obsolete 4/01)
5046 = Radius 20mm cor stent (eff. 1/01) (obsolete 4/01)
5047 = Niroyal Elite Cor Stent Sys (eff. 1/01) (obsolete 4/01)
5048 = GR II Coronary Stent (eff. 1/01) (obsolete 4/01)
5130 = Wilson-Cook Colonic Z-Stent (eff. 1/01) (obsolete 4/01)
5131 = Bard Colorectal Stent-60mm (eff. 1/01) (obsolete 4/01)
5132 = Bard Colorectal Stent-80mm (eff. 1/01) (obsolete 4/01)
5133 = Bard Colorectal Stent-100mm (eff. 1/01) (obsolete 4/01)
5134 = Enteral Wallstent-90mm (eff. 1/01) (obsolete 4/01)
5279 = Contour/Percuflex Stent (eff. 1/01) (obsolete 4/01)
5280 = Inlay Dbl Ureteral Stent (eff. 1/01) (obsolete 4/01)
5281 = Wallgraft Trach Sys 70mm (eff. 1/01) (obsolete 4/01)
5282 = Wallgraft Trach Sys 20/30/50 (eff. 1/01) (obsolete 4/01)
5283 = Wallstent/RP TIPS--80mm (eff. 1/01) (obsolete 4/01)
5284 = Wallstent TrachUltraFlex (eff. 1/01) (obsolete 4/01)
5600 = Closure dev, VasoSeal ES (eff. 1/01) (obsolete 4/01)
5601 = VasoSeal Model 1000 (eff. 1/01) (obsolete 4/01)
6001 = Composix Mesh 8/21 in (eff. 1/01) (obsolete 4/01)
6002 = Composix Mesh 32 in (eff. 1/01) (obsolete 4/01)
6003 = Composix Mesh 48 in (eff. 1/01) (obsolete 4/01)
6004 = Composix Mesh 80 in (eff. 1/01) (obsolete 4/01)
6005 = Composix Mesh 140 in (eff. 1/01) (obsolete 4/01)
6006 = Composix Mesh 144 in (eff. 1/01) (obsolete 4/01)
6012 = Pelvicol Collagen 8/14 sq cm (eff. 1/01) (obsolete 4/01)
6013 = Pelvicol Collagen 21/24/28 sq cm (eff. 1/01) (obsolete 4/01)
6014 = Pelvicol Collagen 36 sq cm (eff. 1/01) (obsolete 4/01)
6015 = Pelvicol Collagen 48 sq cm (eff. 1/01) (obsolete 4/01)
6016 = Pelvicol Collagen 96 sq cm (eff. 1/01) (obsolete 4/01)
6017 = Gore-Tex DualMesh 75/96 sq cm (eff. 1/01) (obsolete 4/01)
6018 = Gore-Tex DualMesh 150 sq cm (eff. 1/01) (obsolete 4/01)
6019 = Gore-Tex DualMesh 285 sq cm (eff. 1/01) (obsolete 4/01)

6020 = Gore-Tex DualMesh 432 sq cm (eff. 1/01) (obsolete 4/01)
6021 = Gore-Tex DualMesh 600 sq cm (eff. 1/01) (obsolete 4/01)
6022 = Gore-Tex DualMesh 884 sq cm (eff. 1/01) (obsolete 4/01)
6023 = Gore-TexPlus 1mm, 75/96 sq cm (eff. 1/01) (obsolete 4/01)
6024 = Gore-TexPlus 1mm, 150 sq cm (eff. 1/01) (obsolete 4/01)
6025 = Gore-TexPlus 1mm, 285 sq cm (eff. 1/01) (obsolete 4/01)
6026 = Gore-TexPlus 1mm, 432 sq cm (eff. 1/01) (obsolete 4/01)
6027 = Gore-TexPlus 1mm, 600 sq cm (eff. 1/01) (obsolete 4/01)
6028 = Gore-TexPlus 1mm, 884 sq cm (eff. 1/01) (obsolete 4/01)
6029 = Gore-TexPlus 2mm, 150 sq cm (eff. 1/01) (obsolete 4/01)
6030 = Gore-TexPlus 2mm, 285 sq cm (eff. 1/01) (obsolete 4/01)
6031 = Gore-TexPlus 2mm, 432 sq cm (eff. 1/01) (obsolete 4/01)
6032 = Gore-TexPlus 2mm, 600 sq cm (eff. 1/01) (obsolete 4/01)
6033 = Gore-TexPlus 2mm, 884 sq cm (eff. 1/01) (obsolete 4/01)
6034 = Bard ePTFE: 150 sq cm-2mm (obsolete 4/01)
6035 = Bard ePTFE: 150sqcm-1mm,75-2mm (eff. 1/01) (obsolete 4/01)
6036 = Bard ePTFE: 50/75sqcm-1,2mm (eff. 1/01) (obsolete 4/01)
6037 = Bard ePTFE: 300 sq cm-1,2mm (eff. 1/01) (obsolete 4/01)
6038 = Bard ePTFE: 600 sq cm-1mm (eff. 1/01) (obsolete 4/01)
6039 = Bard ePTFE: 884sq cm-1mm (eff. 1/01) (obsolete 4/01)
6040 = Bard ePTFE: 600sq cm-2mm (eff. 1/01) (obsolete 4/01)
6041 = Bard ePTFE: 884sq cm -2mm (eff. 1/01) (obsolete 4/01)
6050 = Female Sling Sys w/wo MatrI (eff. 1/01) (obsolete 4/01)
6051 = Stratasis Sling, 20/40 cm (eff. 1/01) (obsolete 4/01)
6052 = Stratasis Sling, 60 cm (eff. 1/01) (obsolete 4/01)
6053 = Surgisis Soft Graft (eff. 1/01) (obsolete 4/01)
6054 = Surgisis Enhanced Graft (eff. 1/01) (obsolete 4/01)
6055 = Surgisis Enhanced Tissue (eff. 1/01) (obsolete 4/01)
6056 = Surgisis Soft Tissue Graft (eff. 1/01) (obsolete 4/01)
6057 = Surgisis Hernia Graft (eff. 1/01) (obsolete 4/01)
6058 = SurgiPro Hernia Plug, med/lg (eff. 1/01) (obsolete 4/01)
6080 = Male Sling Sys w/wo Matrial (eff. 1/01) (obsolete 4/01)
6200 = Exxcel Soft ePTFE vas graft (ef. 1/01) (obsolete 4/01)
6201 = Impra Venaflo--10/20cm (eff. 1/01) (obsolete 4/01)
6202 = Impra Venaflo--30/40 cm (eff. 1/01) (obsolete 4/01)
6203 = Impra Venaflo--50 cm, vt45 (eff. 1/01) (obsolete 4/01)
6204 = Impra Venaflo--stepped (eff. 1/01) (obsolete 4/01)
6205 = Impra Carboflo--10cm (eff. 1/01) (obsolete 4/01)
6206 = Impra Carboflo--20 cm (eff. 1/01) (obsolete 4/01)
6207 = Impra Carboflo--30/35/40cm (eff. 1/01) (obsolete 4/01)
6208 = Impra Carboflo--40/50cm (eff. 1/01) (obsolete 4/01)
6209 = Impra Carboflo--ctrflex (eff. 1/01) (obsolete 4/01)
6210 = Exxcel ePTFE vas graft (eff. 1/01) (obsolete 4/01)
6300 = Vanguard III Endovas Graft (eff. 1/01) (obsolete 4/01)
6500 = Preface Guiding Sheath (eff. 1/01) (obsolete 4/01)
6501 = Soft Tip Sheaths (eff. 1/01) (obsolete 4/01)
6502 = Perry Exchange Dilator (eff. 1/01) (obsolete 4/01)
6525 = Spectranetics Laser Sheath (eff. 1/01) (obsolete 4/01)
6600 = Micro Litho Flex Probes (eff. 1/01) (obsolete 4/01)
6650 = Fast-Cath Guiding Introducer (eff. 1/01) (obsolete 4/01)

6651 = Seal-Away Guding Introducer (eff. 1/01) (obsolete 4/01)
 6652 = Bard Excalibur Introducer (eff. 1/01) (obsolete 4/01)
 6700 = Focal Seal-L (eff. 1/01) (obsolete 4/01)
 7000 = Amifostine, 500 mg (eligible for pass-through payments)
 7001 = Amphotericin B lipid complex, 50 mg, Inj (eligible for pass-through payments)
 7002 = Clonidine, HCl, 1 MG (eligible for pass-through payments) (obsolete 1/01)
 7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-through payments)
 7004 = Immune globulin intravenous human 5g, inj (eligible for pass-through payments)
 7005 = Gonadorelin hcl, 100 mcg (eligible for pass-through payments)
 7007 = Milrinone lactate, per 5 ml, inj (not subject to national coinsurance)
 7010 = Morphine sulfate concentrate (preservative free) per 10 mg (eligible for pass-through payments)
 7011 = Oprelevakin, inj, 5 mg (eligible for pass-through payments)
 7012 = Pentamidine isethionate, 300 mg (eligible for pass-through payments) (obsolete 1/01)
 7014 = Fentanyl citrate, inj, up to 2 ml (eligible for pass-through payments)
 7015 = Busulfan, oral 2 mg (eligible for pass-through payments)
 7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments)
 7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments) (obsolete 1/01)
 7022 = Elliotts B Solution, per ml (eligible for pass-through payments)
 7023 = Treatment for bladder calculi, i.e. Renacidin per 500 ml (eligible for pass-through payments)
 7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments)
 7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments)
 7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments)
 7027 = Fomepizole, 1.5 G (eligible for pass-through payments)
 7028 = Fosphenytoin, 50 mg (eligible for pass-through payments)
 7029 = Glatiramer acetate, 25 mg (eligible for pass-through payments)
 7030 = Hemin, 1 mg (eligible for pass-through payments)
 7031 = Octreotide Acetate, 500 mcg (eligible for pass-through payments)
 7032 = Sermorelin acetate, 0.5 mg (eligible for pass-through payments)
 7033 = Somatrem, 5 mg (eligible for pass-through payments)
 7034 = Somatropin, 1 mg (eligible for pass-through payments)
 7035 = Teniposide, 50 mg (eligible for pass-through payments)
 7036 = Urokinase, inj, IV, 250,000 I.U. (not subject to national coinsurance)
 7037 = Urofollitropin, 75 I.U. (eligible for pass-through payments)
 7038 = Muromonab-CD3, 5 mg (eligible for pass-through payments)
 7039 = Pegademase bovine inj 25 I.U. (eligible for pass-through payments)
 7040 = Pentastarch 10% inj, 100 ml (eligible for pass-through payments)
 7041 = Tirofiban HCL, 0.5 mg (not subject to national coinsurance)
 7042 = Capecitabine, oral 150 mg (eligible for pass-through payments)
 7043 = Infliximab, 10 MG (eligible for pass-through payments)
 7045 = Trimetrexate Glucuronate (eligible for pass-through payments)
 7046 = Doxorubicin Hcl Liposome (eligible for pass-through payments)
 7047 = Droperidol/fentanyl inj (eff. 1/01)
 7048 = Alteplase, 1 mg (eff. 1/01)
 7049 = Filgrastim 480 mcg injection (eff. 1/01)
 7315 = Sodium hyaluronate, 20 mg (eff. 1/01)
 8099 = Spectranetics Lead Lock Dev (eff. 1/01) (obsolete 4/01)

8100 = Adhesion barrier, ADCON-L (eff. 1/01) (obsolete 4/01)
 8102 = SurgiVision Esoph Coil (eff. 1/01) (obsolete 4/01)
 9000 = Na chromate Cr51, per 0.25mCi (eff. 1/01)
 9001 = Linezolid inj, 200mg (eff. 1/01)
 9002 = Tenecteplase, 50mg/vial (eff. 1/01)
 9003 = Palivizumab, per 50 mg (eff. 1/01)
 9004 = Gemtuzumab ozogamicin inj, 5mg (eff. 1/01)
 9005 = Reteplase inj, half-kit, 18.8 mg/vial (eff. 1/01)
 9006 = Tacrolimus inj, per 5 mg (1 amp) (eff. 1/01)
 9007 = Baclofen Intrathecal kit-1amp (eff. 1/01)
 9008 = Baclofen Refill Kit--500mcg (eff. 1/01)
 9009 = Baclofen Refill Kit--2000mcg (eff. 1/01)
 9010 = Baclofen Refill Kit--4000mcg (eff. 1/01)
 9011 = Caffeine Citrate, inj, 1ml (eff. 1/01)
 9012 = Arsenic Trioxide, 1mg/kg (eff. 4/01)
 9013 = Co 57 Cobaltous Cl, 1 ml (eff. 4/01)
 9100 = Iodinated I-131 Albumin (eff. 1/01)
 9102 = 51 Na chromate, 50mCi (eff. 1/01)
 9103 = Na lothalamate I-125, 10uCi (eff. 1/01)
 9104 = Anti-thymocyte globin, 25 mg (eff. 1/01)
 9105 = Hep B immun glob, per 1 ml (eff. 1/01)
 9106 = Sirolimus 1 mg/ml (eff. 1/01)
 9107 = Tinzaparin sodium, 2ml vial (eff. 1/01)
 9108 = Thyrotropin Alfa, 1.1 mg (eff. 1/01)
 9109 = Tirofiban hydrachloride 6.25 mg (eff. 1/01)
 9217 = Leuprolide acetate for depot suspension, 7.5 mg (eff. 1/01)
 9500 = Platelets, irradiated, ea unit (eff. 1/01)
 9501 = Platelets, pheresis, ea unit (eff. 1/01)
 9502 = Platelets, pher/irradiated, ea unit (eff. 1/01)
 9503 = Fresh frozen plasma, ea unit (eff. 1/01)
 9504 = RBC, deglycerolized, ea unit (eff. 1/01)
 9505 = RBC, irradiated, ea unit (eff. 1/01)
 9998 = Enoxaparin (eff. 1/01)

COMMENT: The APC field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

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AT_NPI

LABEL: Claim Attending Physician NPI Number

DESCRIPTION: On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment. NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.

SHORT NAME: AT_NPI

LONG NAME: AT_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: CWF

VALUES: -

COMMENT: -

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AT_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: CWF

VALUES: -

COMMENT: -

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BENE_ID

LABEL: Encrypted CCW Beneficiary ID

DESCRIPTION: The unique CCW identifier for a beneficiary. The CCW assigns a unique beneficiary identification number to each individual who receives Medicare and/ or Medicaid, and uses that number to identify an individual's records in all CCW data files (e.g., Medicare claims, MAX claims, MDS assessment data). This number does not change during a beneficiary's lifetime and each number is used only once. The BENE_ID is specific to the CCW and is not applicable to any other identification system or data source.

SHORT NAME: BENE_ID

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: -

CCW VALUES: -

COMMENT: -

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BENEPMT

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: CWF

VALUES: -

COMMENT: -

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BLDDEDAM

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: -

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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BLDFRNSH

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: CWF

VALUES: -

COMMENT: -

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CARETHRU

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: DERIVATION RULES: Based on the presence of the occurrence code (variable called CLM_RLT_OCRNC_CD) 22. When this code value is present the date is populated using the CLM_RLT_OCRNC_DT.

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CLM_E_POA_IND_SW1

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW1

LONG NAME: CLM_E_POA_IND_SW1

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW2

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW2

LONG NAME: CLM_E_POA_IND_SW2

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW3

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW3

LONG NAME: CLM_E_POA_IND_SW3

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW4

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW4

LONG NAME: CLM_E_POA_IND_SW4

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW5

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW5

LONG NAME: CLM_E_POA_IND_SW5

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW6

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW6

LONG NAME: CLM_E_POA_IND_SW6

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW7

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW7

LONG NAME: CLM_E_POA_IND_SW7

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW8

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW8

LONG NAME: CLM_E_POA_IND_SW8

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW9

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW9

LONG NAME: CLM_E_POA_IND_SW9

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW10

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW10

LONG NAME: CLM_E_POA_IND_SW10

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

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

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CLM_E_POA_IND_SW11

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW11

LONG NAME: CLM_E_POA_IND_SW11

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_E_POA_IND_SW12

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_E_POA_IND_SW12

LONG NAME: CLM_E_POA_IND_SW12

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

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

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CLM_ID

LABEL: Claim ID

DESCRIPTION: This is the unique identification number for the claim. Each Part A or institutional Part B claim has at least one revenue center record. Each non-institutional Part B claim has at least one claim line. All revenue center records or claim lines on a given claim have the same CLM_ID. It is used to link the revenue lines together and/or to the base claim.

SHORT NAME: CLM_ID

LONG NAME: CLM_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

VALUES: -

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

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CLM_LN

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 S

SOURCE: CCW

VALUES: -

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: CWF

VALUES: -

COMMENT: This variable may be null/missing.

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CLM_POA_IND_SW1

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW1

LONG NAME: CLM_POA_IND_SW1

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW2

- LABEL:** Claim Diagnosis Code II Diagnosis Present on Admission (POA) Indicator Code
- DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.
- SHORT NAME:** CLM_POA_IND_SW2
- LONG NAME:** CLM_POA_IND_SW2
- TYPE:** CHAR
- LENGTH:** 1
- SOURCE:** -
- VALUES:** Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.
- COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW3

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW3

LONG NAME: CLM_POA_IND_SW3

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW4

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW4

LONG NAME: CLM_POA_IND_SW4

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW5

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW5

LONG NAME: CLM_POA_IND_SW5

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW6

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW6

LONG NAME: CLM_POA_IND_SW6

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW7

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW7

LONG NAME: CLM_POA_IND_SW7

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW8

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW8

LONG NAME: CLM_POA_IND_SW8

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW9

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW9

LONG NAME: CLM_POA_IND_SW9

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW10

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW10

LONG NAME: CLM_POA_IND_SW10

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW11

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW11

LONG NAME: CLM_POA_IND_SW11

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW12

- LABEL:** Claim Diagnosis Code XII Diagnosis Present on Admission (POA) Indicator Code
- DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.
- SHORT NAME:** CLM_POA_IND_SW12
- LONG NAME:** CLM_POA_IND_SW12
- TYPE:** CHAR
- LENGTH:** 1
- SOURCE:** -
- VALUES:** Y = Diagnosis was present at the time of admission (POA)
- N = Diagnosis was not present at the time of admission
- U = Documentation is insufficient to determine if condition was present on admission
- W = Provider is unable to clinically determine whether condition was present on admission
- 1 = Unreported/not used - exempt from POA reporting - this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
- Z = Denotes the end of the POA indicators
- X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.
- COMMENT:** Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW13

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW13

LONG NAME: CLM_POA_IND_SW13

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW14

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW14

LONG NAME: CLM_POA_IND_SW14

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW15

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW15

LONG NAME: CLM_POA_IND_SW15

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW16

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW16

LONG NAME: CLM_POA_IND_SW16

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW17

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW17

LONG NAME: CLM_POA_IND_SW17

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW18

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW18

LONG NAME: CLM_POA_IND_SW18

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW19

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW19

LONG NAME: CLM_POA_IND_SW19

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW20

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW20

LONG NAME: CLM_POA_IND_SW20

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW21

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW21

LONG NAME: CLM_POA_IND_SW21

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW22

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW22

LONG NAME: CLM_POA_IND_SW22

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW23

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW23

LONG NAME: CLM_POA_IND_SW23

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW24

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW24

LONG NAME: CLM_POA_IND_SW24

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

N = Diagnosis was not present at the time of admission

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

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

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

Z = Denotes the end of the POA indicators

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

COMMENT: Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011. The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

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CLM_POA_IND_SW25

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

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary). In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission. Medicare claims did not indicate whether a diagnosis was POA until 2011.

SHORT NAME: CLM_POA_IND_SW25

LONG NAME: CLM_POA_IND_SW25

TYPE: CHAR

LENGTH: 1

SOURCE: -

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_TYPE

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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CNTY_CD

LABEL: County Code from Claim (SSA)

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

SHORT NAME: CNTY_CD

LONG NAME: BENE_CNTY_CD

TYPE: CHAR

LENGTH: 3

SOURCE: SSA/EDB

VALUES: -

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

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COIN_AMT

LABEL: NCH Beneficiary Part A Coinsurance Liability Amount

DESCRIPTION: The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim. Under Part A, beneficiaries pay coinsurance starting with the 61st day of an inpatient hospital stay (one daily amount for days 61-90, and a higher daily amount for any days after that, which count towards a beneficiary's 60 lifetime reserve days) or the 21st day of a skilled nursing facility (SNF) stay (a daily amount for days 21-100, after which SNF coverage ends). This variable is null/missing for home health and hospice claims.

SHORT NAME: COIN_AMT

LONG NAME: NCH_BENE_PTA_COINSRNC_LBLTY_AM

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: -

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

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COIN_DAY

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: CWF

VALUES: -

COMMENT: -

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CPTL_EXP

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: CWF

VALUES: -

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

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

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CPTL_FSP

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: CWF

VALUES: -

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

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

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CPTLOUTL

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: CWF

VALUES: -

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

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

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DED_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: -

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

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DISP_SHR

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_DSPRRTNT_SHR_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

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

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

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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: CWF

VALUES: -

COMMENT: -

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DRG_CD

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

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

SHORT NAME: DRG_CD

LONG NAME: CLM_DRG_CD

TYPE: CHAR

LENGTH: 3

SOURCE: -

VALUES: -

COMMENT: GROUPER is the software that determines the DRG from data elements reported by the hospital. Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment. Nonpayment claims (zero reimbursement) may not have a DRG present.

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DRGWTAMT

LABEL: Claim PPS Capital DRG Weight Number

DESCRIPTION: The number used to determine a transfer adjusted case mix index for capital PPS. The number is determined by multiplying the DRG weight times the discharge fraction. 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: CWF

VALUES: -

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

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

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DSCHRGDT

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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DSCNTIND

LABEL: Revenue Center Discount Indicator Code

DESCRIPTION: This code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed.

****If there is no discounting the factor will be 1.0****

NOTE1: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

SHORT NAME: DSCNTIND

LONG NAME: REV_CNTR_DSCNT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES: *DISCOUNTING FORMULAS*

1 = 1.0

2 = $(1.0 + D(U - 1)) / U$

3 = T / U

$$4 = (1+D)/U$$

$$5 = D$$

$$6 = TD/U$$

$$7 = D (1+D)/U$$

$$8 = 2.0/U$$
 NOTE: VALUES D, U & T REPRESENT THE FOLLOWING:

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

COMMENT: -

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DSH_OP

LABEL: Operating Disproportionate Share (DSH) Amount

DESCRIPTION: This is one component of the total amount that is payable on 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_DSPRPTNT_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: CCW

VALUES: -

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

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

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

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EXHST_DT

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 (Eff 10/93): 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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FAC_TYPE

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: CWF

VALUES: 1 = Hospital

2 = Skilled Nursing Facility (SNF)

3 = Home Health Agency (HHA)

4 = Religious Non-medical (hospital)

6 = Intermediate Care

7 = Clinic services or hospital based renal dialysis facility

8 = Ambulatory Surgery Center (ASC) or other special facility (e.g. hospice)

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

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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).

SHORT NAME: FI_CLM_PROC_DT

LONG NAME: FI_CLM_PROC_DT

TYPE: DATE

LENGTH: 8

SOURCE: CWF

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: CWF

VALUES: Different FI/MAC carriers are under contract with CMS at different times. See the CMS website for MAC Contract Status (for example): <http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACContractStatus.html>
Fiscal Intermediary Numbers (as of June 2004)

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

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

COMMENT: -

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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: CWF

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 (CWF) generated adjustment claim

H = CMS generated adjustment claim

I = Misc. adjustment claim (e.g., initiated by intermediary or QIO)

J = Other adjustment request

M = Medicare secondary payer (MSP) adjustment

P = Adjustment required by QIO

COMMENT: This field can be used in determining the "type of bill" for institutional claim. Often type of bill consists of a combination of two variables: the facility type code (variable called

CLM_FAC_TYPE_CD) and the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD). This variable serves as the optional third component of bill type, and it is helpful for distinguishing between final, interim, or RAP (request for anticipated payment) claims - which is particularly helpful if you receive claims that are not "final action". Many different types of services can be billed on a Part A or Part B institutional claim, and knowing the type of bill helps to distinguish them. The type of bill is the concatenation of three variables: the facility type (CLM_FAC_TYPE_CD), the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD), and the claim frequency code (CLM_FREQ_CD).

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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: CWF

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

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FST_DGNS_E_CD

LABEL: First Claim Diagnosis E Code

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

SHORT NAME: FST_DGNS_E_CD

LONG NAME: FST_DGNS_E_CD

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

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 the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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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 have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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GNDR_CD

LABEL: Gender Code from Claim

DESCRIPTION: The sex of a beneficiary.

SHORT NAME: GNDR_CD

LONG NAME: GNDR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: SSA, RRB, EDB

VALUES: 0 = Unknown

1 = Male

2 = Female

COMMENT: -

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HCPCS_CD

LABEL: Healthcare Common Procedure Coding System (HCPCS) Code

DESCRIPTION: The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below (in COMMENT): In the Institutional Claim Revenue Center Files, this variable can indicate the specific case-mix grouping that Medicare used to pay for skilled nursing facility (SNF), home health, or inpatient rehabilitation facility (IRF) services (see Note 2 in COMMENT section below).

SHORT NAME: HCPCS_CD

LONG NAME: HCPCS_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES: -

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

**** Note 1: ****

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

Level II

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

Level III

Codes and descriptors developed by Medicare carriers (currently known as Medicare Administrative Contractors; MACs) for use at the local (MAC) level. These are 5-position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician

services that are not represented in the level I or level II codes.

**** Note 2: ****

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

HIPPS code if the revenue center code (REV_CNTR) equals 0022 for SNF care, 0023 for home health, or 0024 for IRF care. For home health claims, please also see the revenue center APC/HIPPS code variable (REV_CNTR_APC_HIPPS_CD).

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HHA_RFRL

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: CWF

VALUES:

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

to another unrelated HHA under HH PPS. (eff.10/00)

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

COMMENT: The use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00) Beginning 10/1/00, this field was populated with data. Claims processed prior to 10/1/00 contained spaces in this field.

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HHSTRTDT

LABEL: Claim HHA Care Start Date

DESCRIPTION: The date care started for the HHA services reported on the institutional claim.

SHORT NAME: HHSTRTDT

LONG NAME: CLM_ADMSN_DT

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: Date the home health plan established or last reviewed.
Field is not well populated until after 2011.

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HLDHRMLS

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. 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: HLDHRMLS

LONG NAME: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

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

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

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HOSPCPRD

LABEL: Beneficiary's Hospice Period Count

DESCRIPTION: The count of the number of hospice period trailers present for the beneficiary's record. Medicare covers hospice benefit periods which may consist of 2 initial 90 day periods followed by an unlimited number of 60 day periods. Hospice benefits are generally in lieu of standard Part A hospital benefits for treating the terminal condition.

SHORT NAME: HOSPCPRD

LONG NAME: BENE_HOSPC_PRD_CNT

TYPE: NUM

LENGTH: 1

SOURCE: CWF

VALUES: -

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

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

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HSPCSTRT

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: CWF

VALUES: -

COMMENT: -

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ICD_DGNS_CD1

LABEL: Claim Diagnosis Code I

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

SHORT NAME: ICD_DGNS_CD1

LONG NAME: ICD_DGNS_CD1

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non- institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD2

LABEL: Claim Diagnosis Code II

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

SHORT NAME: ICD_DGNS_CD2

LONG NAME: ICD_DGNS_CD2

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non- institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD3

LABEL: Claim Diagnosis Code III

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

SHORT NAME: ICD_DGNS_CD3

LONG NAME: ICD_DGNS_CD3

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non- institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD4

LABEL: Claim Diagnosis Code IV

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

SHORT NAME: ICD_DGNS_CD4

LONG NAME: ICD_DGNS_CD4

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD5

LABEL: Claim Diagnosis Code V

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

SHORT NAME: ICD_DGNS_CD5

LONG NAME: ICD_DGNS_CD5

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD6

LABEL: Claim Diagnosis Code VI

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

SHORT NAME: ICD_DGNS_CD6

LONG NAME: ICD_DGNS_CD6

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD7

LABEL: Claim Diagnosis Code VII

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

SHORT NAME: ICD_DGNS_CD7

LONG NAME: ICD_DGNS_CD7

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD8

LABEL: Claim Diagnosis Code VIII

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

SHORT NAME: ICD_DGNS_CD8

LONG NAME: ICD_DGNS_CD8

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD9

LABEL: Claim Diagnosis Code IX

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

SHORT NAME: ICD_DGNS_CD9

LONG NAME: ICD_DGNS_CD9

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD10

LABEL: Claim Diagnosis Code X

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

SHORT NAME: ICD_DGNS_CD10

LONG NAME: ICD_DGNS_CD10

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non- institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD11

LABEL: Claim Diagnosis Code XI

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

SHORT NAME: ICD_DGNS_CD11

LONG NAME: ICD_DGNS_CD11

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD12

LABEL: Claim Diagnosis Code XII

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

SHORT NAME: ICD_DGNS_CD12

LONG NAME: ICD_DGNS_CD12

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non- institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD13

LABEL: Claim Diagnosis Code XIII

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

SHORT NAME: ICD_DGNS_CD13

LONG NAME: ICD_DGNS_CD13

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD14

LABEL: Claim Diagnosis Code XIV

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

SHORT NAME: ICD_DGNS_CD14

LONG NAME: ICD_DGNS_CD14

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD15

LABEL: Claim Diagnosis Code XV

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

SHORT NAME: ICD_DGNS_CD15

LONG NAME: ICD_DGNS_CD15

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD16

LABEL: Claim Diagnosis Code XVI

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

SHORT NAME: ICD_DGNS_CD16

LONG NAME: ICD_DGNS_CD16

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD17

LABEL: Claim Diagnosis Code XVII

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

SHORT NAME: ICD_DGNS_CD17

LONG NAME: ICD_DGNS_CD17

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD18

LABEL: Claim Diagnosis Code XVIII

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

SHORT NAME: ICD_DGNS_CD18

LONG NAME: ICD_DGNS_CD18

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD19

LABEL: Claim Diagnosis Code XIX

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

SHORT NAME: ICD_DGNS_CD19

LONG NAME: ICD_DGNS_CD19

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD20

LABEL: Claim Diagnosis Code XX

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

SHORT NAME: ICD_DGNS_CD20

LONG NAME: ICD_DGNS_CD20

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD21

LABEL: Claim Diagnosis Code XXI

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

SHORT NAME: ICD_DGNS_CD21

LONG NAME: ICD_DGNS_CD21

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD22

LABEL: Claim Diagnosis Code XXII

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

SHORT NAME: ICD_DGNS_CD22

LONG NAME: ICD_DGNS_CD22

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD23

LABEL: Claim Diagnosis Code XXIII

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

SHORT NAME: ICD_DGNS_CD23

LONG NAME: ICD_DGNS_CD23

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD24

LABEL: Claim Diagnosis Code XXIV

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

SHORT NAME: ICD_DGNS_CD24

LONG NAME: ICD_DGNS_CD24

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_CD25

LABEL: Claim Diagnosis Code XXV

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

SHORT NAME: ICD_DGNS_CD25

LONG NAME: ICD_DGNS_CD25

TYPE: CHAR

LENGTH: 7

SOURCE: -

VALUES: -

COMMENT: For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

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ICD_DGNS_E_CD1

LABEL: Claim Diagnosis E Code I

DESCRIPTION: The code used to identify the 1st external cause of injury, poisoning, or other adverse effect.

SHORT NAME: ICD_DGNS_E_CD1

LONG NAME: ICD_DGNS_E_CD1

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD2

LABEL: Claim Diagnosis E Code II

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

SHORT NAME: ICD_DGNS_E_CD2

LONG NAME: ICD_DGNS_E_CD2

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD3

LABEL: Claim Diagnosis E Code III

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

SHORT NAME: ICD_DGNS_E_CD3

LONG NAME: ICD_DGNS_E_CD3

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD4

LABEL: Claim Diagnosis E Code IV

DESCRIPTION: The code used to identify the 4th external cause of injury, poisoning, or other adverse effect.

SHORT NAME: ICD_DGNS_E_CD4

LONG NAME: ICD_DGNS_E_CD4

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD5

LABEL: Claim Diagnosis E Code V

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

SHORT NAME: ICD_DGNS_E_CD5

LONG NAME: ICD_DGNS_E_CD5

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD6

LABEL: Claim Diagnosis E Code VI

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

SHORT NAME: ICD_DGNS_E_CD6

LONG NAME: ICD_DGNS_E_CD6

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD7

LABEL: Claim Diagnosis E Code VII

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

SHORT NAME: ICD_DGNS_E_CD7

LONG NAME: ICD_DGNS_E_CD7

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD8

LABEL: Claim Diagnosis E Code VIII

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

SHORT NAME: ICD_DGNS_E_CD8

LONG NAME: ICD_DGNS_E_CD8

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD9

LABEL: Claim Diagnosis E Code IX

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

SHORT NAME: ICD_DGNS_E_CD9

LONG NAME: ICD_DGNS_E_CD9

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD10

LABEL: Claim Diagnosis E Code X

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

SHORT NAME: ICD_DGNS_E_CD10

LONG NAME: ICD_DGNS_E_CD10

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD11

LABEL: Claim Diagnosis E Code XI

DESCRIPTION: The code used to identify the 11th external cause of injury, poisoning, or other adverse effect.

SHORT NAME: ICD_DGNS_E_CD11

LONG NAME: ICD_DGNS_E_CD11

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_CD12

LABEL: Claim Diagnosis E Code XII

DESCRIPTION: The code used to identify the 12th external cause of injury, poisoning, or other adverse effect.

SHORT NAME: ICD_DGNS_E_CD12

LONG NAME: ICD_DGNS_E_CD12

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD1

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD1

LONG NAME: ICD_DGNS_E_VRSN_CD1

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD2

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD2

LONG NAME: ICD_DGNS_E_VRSN_CD2

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD3

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD3

LONG NAME: ICD_DGNS_E_VRSN_CD3

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD4

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD4

LONG NAME: ICD_DGNS_E_VRSN_CD4

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD5

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD5

LONG NAME: ICD_DGNS_E_VRSN_CD5

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD6

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD6

LONG NAME: ICD_DGNS_E_VRSN_CD6

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD7

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD7

LONG NAME: ICD_DGNS_E_VRSN_CD7

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD8

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD8

LONG NAME: ICD_DGNS_E_VRSN_CD8

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD9

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD9

LONG NAME: ICD_DGNS_E_VRSN_CD9

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD10

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD10

LONG NAME: ICD_DGNS_E_VRSN_CD10

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD11

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD11

LONG NAME: ICD_DGNS_E_VRSN_CD11

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_E_VRSN_CD12

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

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

SHORT NAME: ICD_DGNS_E_VRSN_CD12

LONG NAME: ICD_DGNS_E_VRSN_CD12

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: With 5010, the diagnosis and procedure codes have been expanded to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD1

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

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

SHORT NAME: ICD_DGNS_VRSN_CD1

LONG NAME: ICD_DGNS_VRSN_CD1

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD2

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

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

SHORT NAME: ICD_DGNS_VRSN_CD2

LONG NAME: ICD_DGNS_VRSN_CD2

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD3

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

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

SHORT NAME: ICD_DGNS_VRSN_CD3

LONG NAME: ICD_DGNS_VRSN_CD3

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD4

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

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

SHORT NAME: ICD_DGNS_VRSN_CD4

LONG NAME: ICD_DGNS_VRSN_CD4

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD5

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

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

SHORT NAME: ICD_DGNS_VRSN_CD5

LONG NAME: ICD_DGNS_VRSN_CD5

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD6

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

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

SHORT NAME: ICD_DGNS_VRSN_CD6

LONG NAME: ICD_DGNS_VRSN_CD6

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD7

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

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

SHORT NAME: ICD_DGNS_VRSN_CD7

LONG NAME: ICD_DGNS_VRSN_CD7

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD8

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

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

SHORT NAME: ICD_DGNS_VRSN_CD8

LONG NAME: ICD_DGNS_VRSN_CD8

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD9

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

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

SHORT NAME: ICD_DGNS_VRSN_CD9

LONG NAME: ICD_DGNS_VRSN_CD9

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD10

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

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

SHORT NAME: ICD_DGNS_VRSN_CD10

LONG NAME: ICD_DGNS_VRSN_CD10

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD11

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

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

SHORT NAME: ICD_DGNS_VRSN_CD11

LONG NAME: ICD_DGNS_VRSN_CD11

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD12

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

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

SHORT NAME: ICD_DGNS_VRSN_CD12

LONG NAME: ICD_DGNS_VRSN_CD12

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD13

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

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

SHORT NAME: ICD_DGNS_VRSN_CD13

LONG NAME: ICD_DGNS_VRSN_CD13

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD14

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

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

SHORT NAME: ICD_DGNS_VRSN_CD14

LONG NAME: ICD_DGNS_VRSN_CD14

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD15

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

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

SHORT NAME: ICD_DGNS_VRSN_CD15

LONG NAME: ICD_DGNS_VRSN_CD15

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD16

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

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

SHORT NAME: ICD_DGNS_VRSN_CD16

LONG NAME: ICD_DGNS_VRSN_CD16

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD17

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

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

SHORT NAME: ICD_DGNS_VRSN_CD17

LONG NAME: ICD_DGNS_VRSN_CD17

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD18

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

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

SHORT NAME: ICD_DGNS_VRSN_CD18

LONG NAME: ICD_DGNS_VRSN_CD18

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD19

LABEL: Claim Diagnosis Code XIX 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 or ICD-10.

SHORT NAME: ICD_DGNS_VRSN_CD19

LONG NAME: ICD_DGNS_VRSN_CD19

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD20

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

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

SHORT NAME: ICD_DGNS_VRSN_CD20

LONG NAME: ICD_DGNS_VRSN_CD20

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD21

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

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

SHORT NAME: ICD_DGNS_VRSN_CD21

LONG NAME: ICD_DGNS_VRSN_CD21

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD22

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

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

SHORT NAME:

LONG NAME: ICD_DGNS_VRSN_CD22

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD23

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

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

SHORT NAME: ICD_DGNS_VRSN_CD23

LONG NAME: ICD_DGNS_VRSN_CD23

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD24

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

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

SHORT NAME: ICD_DGNS_VRSN_CD24

LONG NAME: ICD_DGNS_VRSN_CD24

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_DGNS_VRSN_CD25

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

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

SHORT NAME: ICD_DGNS_VRSN_CD25

LONG NAME: ICD_DGNS_VRSN_CD25

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_CD1

LABEL: Claim Procedure Code I

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

SHORT NAME: ICD_PRCDR_CD1

LONG NAME: ICD_PRCDR_CD1

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD2

LABEL: Claim Procedure Code II

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

SHORT NAME: ICD_PRCDR_CD2

LONG NAME: ICD_PRCDR_CD2

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD3

LABEL: Claim Procedure Code III

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

SHORT NAME: ICD_PRCDR_CD3

LONG NAME: ICD_PRCDR_CD3

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD4

LABEL: Claim Procedure Code IV

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

SHORT NAME: ICD_PRCDR_CD4

LONG NAME: ICD_PRCDR_CD4

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD5

LABEL: Claim Procedure Code V

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

SHORT NAME: ICD_PRCDR_CD5

LONG NAME: ICD_PRCDR_CD5

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD6

LABEL: Claim Procedure Code VI

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

SHORT NAME: ICD_PRCDR_CD6

LONG NAME: ICD_PRCDR_CD6

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD7

LABEL: Claim Procedure Code VII

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

SHORT NAME: ICD_PRCDR_CD7

LONG NAME: ICD_PRCDR_CD7

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD8

LABEL: Claim Procedure Code VIII

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

SHORT NAME: ICD_PRCDR_CD8

LONG NAME: ICD_PRCDR_CD8

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD9

LABEL: Claim Procedure Code IX

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

SHORT NAME: ICD_PRCDR_CD9

LONG NAME: ICD_PRCDR_CD9

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD10

LABEL: Claim Procedure Code X

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

SHORT NAME: ICD_PRCDR_CD10

LONG NAME: ICD_PRCDR_CD10

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD11

LABEL: Claim Procedure Code XI

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

SHORT NAME: ICD_PRCDR_CD11

LONG NAME: ICD_PRCDR_CD11

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD12

LABEL: Claim Procedure Code XII

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

SHORT NAME: ICD_PRCDR_CD12

LONG NAME: ICD_PRCDR_CD12

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD13

LABEL: Claim Procedure Code XIII

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

SHORT NAME: ICD_PRCDR_CD13

LONG NAME: ICD_PRCDR_CD13

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD14

LABEL: Claim Procedure Code XIV

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

SHORT NAME: ICD_PRCDR_CD14

LONG NAME: ICD_PRCDR_CD14

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD15

LABEL: Claim Procedure Code XV

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

SHORT NAME: ICD_PRCDR_CD15

LONG NAME: ICD_PRCDR_CD15

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD16

LABEL: Claim Procedure Code XVI

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

SHORT NAME: ICD_PRCDR_CD16

LONG NAME: ICD_PRCDR_CD16

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD17

LABEL: Claim Procedure Code XVII

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

SHORT NAME: ICD_PRCDR_CD17

LONG NAME: ICD_PRCDR_CD17

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD18

LABEL: Claim Procedure Code XVIII

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

SHORT NAME: ICD_PRCDR_CD18

LONG NAME: ICD_PRCDR_CD18

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD19

LABEL: Claim Procedure Code XIX

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

SHORT NAME: ICD_PRCDR_CD19

LONG NAME: ICD_PRCDR_CD19

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD20

LABEL: Claim Procedure Code XX

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

SHORT NAME: ICD_PRCDR_CD20

LONG NAME: ICD_PRCDR_CD20

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD21

LABEL: Claim Procedure Code XXI

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

SHORT NAME: ICD_PRCDR_CD21

LONG NAME: ICD_PRCDR_CD21

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD22

LABEL: Claim Procedure Code XXII

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

SHORT NAME: ICD_PRCDR_CD22

LONG NAME: ICD_PRCDR_CD22

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD23

LABEL: Claim Procedure Code XXIII

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

SHORT NAME: ICD_PRCDR_CD23

LONG NAME: ICD_PRCDR_CD23

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD24

LABEL: Claim Procedure Code XXIV

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

SHORT NAME: ICD_PRCDR_CD24

LONG NAME: ICD_PRCDR_CD24

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_CD25

LABEL: Claim Procedure Code XXV

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

SHORT NAME: ICD_PRCDR_CD25

LONG NAME: ICD_PRCDR_CD25

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

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ICD_PRCDR_VRSN_CD1

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD1

LONG NAME: ICD_PRCDR_VRSN_CD1 T

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD2

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD2

LONG NAME: ICD_PRCDR_VRSN_CD2

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD3

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD3

LONG NAME: ICD_PRCDR_VRSN_CD3

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD4

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD4

LONG NAME: ICD_PRCDR_VRSN_CD4

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD5

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD5

LONG NAME: ICD_PRCDR_VRSN_CD5

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD6

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD6

LONG NAME: ICD_PRCDR_VRSN_CD6

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD7

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD7

LONG NAME: ICD_PRCDR_VRSN_CD7

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD8

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD8

LONG NAME: ICD_PRCDR_VRSN_CD8

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD9

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD9

LONG NAME: ICD_PRCDR_VRSN_CD9

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD10

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD10

LONG NAME: ICD_PRCDR_VRSN_CD10

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD11

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD11

LONG NAME: ICD_PRCDR_VRSN_CD11

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD12

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD12

LONG NAME: ICD_PRCDR_VRSN_CD12

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD13

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD13

LONG NAME: ICD_PRCDR_VRSN_CD13

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD14

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD14

LONG NAME: ICD_PRCDR_VRSN_CD14

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD15

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD15

LONG NAME: ICD_PRCDR_VRSN_CD15

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD16

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD16

LONG NAME: ICD_PRCDR_VRSN_CD16

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD17

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD17

LONG NAME: ICD_PRCDR_VRSN_CD17

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD18

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD18

LONG NAME: ICD_PRCDR_VRSN_CD18

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD19

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD19

LONG NAME: ICD_PRCDR_VRSN_CD19

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD20

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD20

LONG NAME: ICD_PRCDR_VRSN_CD20

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD21

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD21

LONG NAME: ICD_PRCDR_VRSN_CD21

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD22

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD22

LONG NAME: ICD_PRCDR_VRSN_CD22

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD23

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD23

LONG NAME: ICD_PRCDR_VRSN_CD23

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD24

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD24

LONG NAME: ICD_PRCDR_VRSN_CD24

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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ICD_PRCDR_VRSN_CD25

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

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

SHORT NAME: ICD_PRCDR_VRSN_CD25

LONG NAME: ICD_PRCDR_VRSN_CD25

TYPE: CHAR

LENGTH: 1

SOURCE: -

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

COMMENT: ICD-10 is not scheduled for implementation until 10/2015.

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IDENDC

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: CWF

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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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 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: CWF

VALUES: -

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called "Payment Basics"
(see: http://www.medpac.gov/payment_basics.cfm)
Also in the Medicare Learning Network (MLN) "Payment System Fact Sheet Series"
(see: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html>).

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IME_OP

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: CCW

VALUES: -

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

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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LRD_USE

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

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

SHORT NAME: LRD_USE

LONG NAME: BENE_LRD_USED_CNT

TYPE: NUM

LENGTH: 3

SOURCE: -

VALUES: -

COMMENT: -

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LUPAIND

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: CWF

VALUES: L = Low utilization payment adjustment (LUPA) claim

Blank = Not a LUPA claim; process using Home Health resource groups (HHRG)

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

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MCOPDSW

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: CWF

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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MDFR_CD1

LABEL: HCPCS Initial Modifier Code

DESCRIPTION: A first modifier to the 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: CWF

VALUES: -

COMMENT: -

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MDFR_CD2

LABEL: HCPCS Second Modifier Code

DESCRIPTION: A second modifier to the 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: CWF

VALUES: -

COMMENT: -

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NCCHGAMT

LABEL: NCH Inpatient(or other Part A) Noncovered Charge Amount

DESCRIPTION: The noncovered charges for all accommodations and services, reported on an inpatient claim (used for internal CWFMQA editing purposes).

SHORT NAME: NCCHGAMT

LONG NAME: NCH_IP_NCVRD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process VALUES:

COMMENT: -

DERIVED FROM: REV_CNTR_CD REV_CNTR_NCVR_CHRG_AMT.

DERVIATION RULES: Based on the presence of revenue center code equal to 0001, move the related noncovered charge amount to NCH_IP_NCOV_CHRG_AMT.

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NCOVFROM

LABEL: NCH Verified Noncovered Stay From Date

DESCRIPTION: The beginning date of the beneficiary's noncovered 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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NCOVTHRU

LABEL: NCH Verified Noncovered Stay Through Date

DESCRIPTION: The ending date of the beneficiary's noncovered 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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NOPAY_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: -

VALUES: A = Covered worker's compensation (Obsolete)
B = Benefit exhausted
C = Custodial care - noncovered 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. 7/00)
F = MSP cost avoid HMO Rate Cell (eff. 7/00)
G = MSP cost avoided Litigation Settlement (eff. 7/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/00) J = MSP cost avoid Insurer
Voluntary Reporting (eff. 7/00)
K = MSP cost avoid Initial Enrollment Questionnaire (eff. 7/00)
N = All other reasons for non-payment
P = Payment requested

Q = MSP cost avoided Voluntary Agreement (eff. 7/00) R = Benefits refused, or evidence not submitted

T = MSP cost avoided - IEQ contractor (eff. 9/76) (obsolete 6/30/00)

U = MSP cost avoided - HMO rate cell adjustment (eff. 9/76) (Obsolete 6/30/00)

V = MSP cost avoided - litigation settlement (eff. 9/76) (Obsolete 6/30/00)

W = Worker's compensation (Obsolete)

X = MSP cost avoided - generic

Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)

Z = Zero reimbursement RAPs -- zero reimbursement made due to medical review intervention or where provider specific zero payment has been determined. (effective with HHPPS - 10/00)

00 = MSP cost avoided - COB Contractor

12 = MSP cost avoided - BCBS Voluntary Agreements

13= MSP cost avoided - Office of Personnel Management

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

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

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

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

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

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

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

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

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

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

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

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

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

!= MSP cost avoided - COB Contractor ('00' 2-byte code)

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

#= MSP cost avoided - Office of Personnel Management ('13' 2-byte code)

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

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

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

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

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

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

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

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

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

COMMENT: NOTE1: This field was put on all institutional claim types but data did not start coming in on OP/HHA/Hospice until 4/1/02. Prior to 4/1/02, data only came in Inpatient/SNF claims.

NOTE2: Effective 4/1/02, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

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

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NUTILDAY

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: CWF

VALUES: -

COMMENT: -

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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:

LONG NAME: CLM_RLT_OCRNC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: CWF

VALUES: 01 THRU 09 = Accident

10 THRU 19 = Medical condition

20 THRU 39 = Insurance related

40 THRU 69 = Service related

A1 - A3 = Miscellaneous

=====

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

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

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

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

05 = Other accident - The date of an accident no

described by the codes 01 thru 04.

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

07 = Reserved for national assignment.

08 = Reserved for national assignment.

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

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

13 = Reserved for national assignment.

14 = Reserved for national assignment.

15 = Reserved for national assignment.

16 = Reserved for national assignment.

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

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

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

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

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

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

code "21" is used.

- 23 = Cancellation of Hospice benefits – The date the RHHI cancelled the hospice benefit. (eff. 10/00). NOTE: this will be different than the revocation of the hospice benefit by beneficiaries.
- 24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.
- 25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.
- 26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
- 27 = Date of Hospice Certification or Re-Certification -- code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/01)
- 27 = Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed. (Obsolete) not used by hospital unless owner of facility
- 28 = Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed. Not used by hospital unless owner of facility
- 29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy. Not used by hospital unless owner of facility
- 30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed. Not used by hospital unless owner of facility
- 31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.
- 32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.

- 33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
- 34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
- 35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
- 36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.
- 37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppressive drugs.
- 38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.
- 39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.
- 40 = Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
- 41 = Date of First Test for Pre-admission Testing - The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/01)
- 42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Date patient revoked hospice election.
- 43 = Scheduled Date of Canceled Surgery – date which ambulatory surgery was scheduled. (eff. 9/01)
- 44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.
- 45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.
- 46 = Date treatment started for cardiac rehabilitation Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
- 47 = Date Cost Outlier Status Begins – code indicates that this is the first day the cost

outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)

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

49 = Payer code - Code reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers will not report it. 50-69 = Reserved for state assignment

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

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

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

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

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

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

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

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

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

COMMENT: -

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OCRNCDT

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: CWF

VALUES: -

COMMENT: -

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OP_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: CWF

VALUES: -

COMMENT: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy numbers) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

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OP_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: CWF

VALUES: -

COMMENT: -

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ORGNPINM

LABEL: Organization NPI Number

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

SHORT NAME: ORGNPINM

LONG NAME: ORG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: CWF

VALUES: -

COMMENT:

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OT_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: CWF

VALUES: -

COMMENT: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy numbers) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

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OT_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: CWF

VALUES: -

COMMENT:

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OTAF_1

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: CWF

VALUES: -

COMMENT: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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OUTLR_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: CWF

VALUES: 0 = No outlier

1 = Day outlier (condition code 60)

2 = Cost outlier (condition code 61)

*** Non-PPS Only ***

6 = Valid diagnosis related groups (DRG) received from the intermediary

7 = CMS developed DRG

8 = CMS developed DRG using patient status code

9 = Not groupable

COMMENT: -

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OUTLRPMT

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. 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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PACKGIND

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: CWF

VALUES: 0 = Not packaged

1 = Packaged service (service indicator N)

2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem

3 = Artificial charges for surgical procedure (eff. 7/2004)

COMMENT: NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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PCCHGAMT

LABEL: NCH Professional Component Charge Amount

DESCRIPTION: The amount of physician and other professional charges covered under Medicare Part B. For IP claims, this amount is not reflected in any of the other Part A claim fields (i.e., it is not a portion of the Medicare payment for the hospitalization).

SHORT NAME: PCCHGAMT

LONG NAME: NCH_PROFNL_CMPNT_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: -

COMMENT: -

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PER_DIEM

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: CWF

VALUES: -

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

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PMT_AMT

LABEL: Claim (Medicare) Payment Amount DESCRIPTION: The Medicare claim payment amount. For hospital services, this amount does not include the claim pass-through per diem payments made by Medicare. To obtain the total amount paid by Medicare for the claim, the pass-through amount (which is the daily per diem amount) must be multiplied by the number of Medicare-covered days (i.e., multiply the CLM_PASS_THRU_PER_DIEM_AMT by the CLM_UTLZTN_DAY_CNT), and then added to the claim payment amount (this field). For non-hospital services (SNF, home health, hospice, and hospital outpatient) and for other non-institutional services (Carrier and DME), this variable equals the total actual Medicare payment amount, and pass-through amounts do not apply. For Part B non-institutional services (Carrier and DME), this variable equals the sum of all the line item-level Medicare payments (variable called the LINE_NCH_PMT_AMT).

SHORT NAME: PMT_AMT

LONG NAME: CLM_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

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

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PMTMTHD

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: CWF

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

1 = Paid standard hospital OPPS amount (status indicators K, S,T,V,X)

2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes)

3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z)

4 = Paid at reasonable cost (status indicator F,L)

5 = Additional payment for drug or biological (status indicator G)

6 = Additional payment for device (status indicator H)

7 = Additional payment for new drug or new biological (status indicator J)

8 = Paid partial hospitalization per diem (status indicator P)

9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services)

*****VALUES PRIOR TO 10/3/2005*****

*****Service Status Indicator*****

***** 1st position *****

A = Services not paid under OPPS

C = Inpatient procedure

E = Noncovered items or services

F = Corneal tissue acquisition

G = Current drug or biological pass-through

H = Device pass-through

J = New drug or new biological pass-through

N = Packaged incidental service

P = Partial hospitalization services

S = Significant procedure not subject to multiple procedure discounting

T = Significant procedure subject to multiple procedure discounting

V = Medical visit to clinic or emergency department

X = Ancillary service

*****Payment Indicator*****

***** 2nd position *****

1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)

2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)

3 = Not paid (service indicators C & E)

4 = Acquisition cost paid (service indicator F)

5 = Additional payment for current drug or biological (service

indicator G)

6 = Additional payment for device (service indicator H)

7 = Additional payment for new drug or new biological (service indicator J)

8 = Paid partial hospitalization per diem (service indicator P)

9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)

COMMENT: NOTE: 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.

NOTE1: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.-

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PPS_CPTL

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: CWF

VALUES: -

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

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PPS_IND

LABEL: Claim PPS Indicator Code

DESCRIPTION: The code indicating whether or not: the claim is from the prospective payment system (PPS) and/or 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: CWF

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

COMMENT: -

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PRCDR_DT1

LABEL: Claim Procedure Code I Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME:

LONG NAME: PRCDR_DT1

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT2

LABEL: Claim Procedure Code II Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT2

LONG NAME: PRCDR_DT2

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT3

LABEL: Claim Procedure Code III Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT3

LONG NAME: PRCDR_DT3

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT4

LABEL: Claim Procedure Code IV Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME:

LONG NAME: PRCDR_DT4

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT5

LABEL: Claim Procedure Code V Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT5

LONG NAME: PRCDR_DT5

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT6

LABEL: Claim Procedure Code VI Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT6

LONG NAME: PRCDR_DT6

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT7

LABEL: Claim Procedure Code VII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT7

LONG NAME: PRCDR_DT7

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT8

LABEL: Claim Procedure Code VIII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT8

LONG NAME: PRCDR_DT8

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT9

LABEL: Claim Procedure Code IX Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT9

LONG NAME: PRCDR_DT9

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT10

LABEL: Claim Procedure Code X Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT10

LONG NAME: PRCDR_DT10

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT11

LABEL: Claim Procedure Code XI Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT11

LONG NAME: PRCDR_DT11

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT12

LABEL: Claim Procedure Code XII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT12

LONG NAME: PRCDR_DT12

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT13

LABEL: Claim Procedure Code XIII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT13

LONG NAME: PRCDR_DT13

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT14

LABEL: Claim Procedure Code XIV Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT14

LONG NAME: PRCDR_DT14

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT15

LABEL: Claim Procedure Code XV Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT15

LONG NAME: PRCDR_DT15

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT16

LABEL: Claim Procedure Code XVI Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT16

LONG NAME: PRCDR_DT16

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT17

LABEL: Claim Procedure Code XVII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT17

LONG NAME: PRCDR_DT17

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT18

LABEL: Claim Procedure Code XVIII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT18

LONG NAME: PRCDR_DT18

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT19

LABEL: Claim Procedure Code XIX Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT19

LONG NAME: PRCDR_DT19

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT20

LABEL: Claim Procedure Code XX Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT20

LONG NAME: PRCDR_DT20

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT21

LABEL: Claim Procedure Code XXI Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT21

LONG NAME: PRCDR_DT21

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT22

LABEL: Claim Procedure Code XXII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT22

LONG NAME: PRCDR_DT22

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT23

LABEL: Claim Procedure Code XXIII Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT23

LONG NAME: PRCDR_DT23

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT24

LABEL: Claim Procedure Code XXIV Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT24

LONG NAME: PRCDR_DT24

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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PRCDR_DT25

LABEL: Claim Procedure Code XXV Date

DESCRIPTION: The date on which the principal or other procedure was performed.

SHORT NAME: PRCDR_DT25

LONG NAME: PRCDR_DT25

TYPE: DATE

LENGTH: 8

SOURCE: CWF

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: CWF

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 the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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PRNCPAL_DGNS_VRSN_CD

LABEL: Claim Principal Diagnosis Version Code

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

SHORT NAME: PRNCPAL_DGNS_VRSN_CD

LONG NAME: PRNCPAL_DGNS_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 have been expanded to accommodate ICD-10. ICD-10 is not scheduled for implementation until 10/2015.

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PROVIDER

LABEL: Provider Number

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

SHORT NAME: PROVIDER

LONG NAME: PRVDR_NUM

TYPE: CHAR

LENGTH: 6

SOURCE: -

VALUES: The following blocks of numbers are reserved for the facilities indicated (NOTE: may have different meanings dependent on the Type of Bill [TOB]):

0001-0879	Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899	Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999	Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199	Reserved for future use
1200-1224	Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399	Critical Access Hospitals (CAH)
1400-1499	Continuation of 4900-4999 series (CMHC)
1500-1799	Hospices

1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999	Religious Nonmedical Health Care Institutions (RNHCI)
2000-2299	Long-term hospitals
2300-2499	Chronic renal disease facilities (hospital based)
2500-2899	Non-hospital renal disease treatment centers
2900-2999	Independent special purpose renal dialysis facility (1)
3000-3024	Formerly tuberculosis hospitals (numbers retired)
3025-3099	Rehabilitation hospitals
3100-3199	Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3)
3200-3299	Continuation of 4800-4899 series (CORF)
3300-3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499	Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699	Renal disease treatment centers (hospital satellites)
3700-3799	Hospital based special purpose renal dialysis facility (1)
3800-3974	Rural health clinics (free-standing)
3975-3999	Rural health clinics (provider-based)
4000-4499	Psychiatric hospitals
4500-4599	Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799	Community Mental Health Centers (CMHC)
4800-4899	Continuation of 4500-4599 series (CORF)
4900-4999	Continuation of 4600-4799 series (CMHC)
5000-6499	Skilled Nursing Facilities
6500-6989	CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X

6990-6999	Numbers reserved (formerly Christian Science)
7000-7299	Home Health Agencies (HHA) (2)
7300-7399	Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)
7400-7799	Continuation of 7000-7299 series
7800-7999	Subunits of state and local governmental Home Health Agencies (3)
8000-8499	Continuation of 7400-7799 series (HHA)
8500-8899	Continuation of rural health center (provider based) (3400-3499)
8900-8999	Continuation of rural health center (free-standing) (3800-3974)
9000-9799	Continuation of 8000-8499 series (HHA)
9800-9899	Transplant Centers (eff. 10/1/07)
9900-9999	Reserved for future use

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

- M = Psychiatric Unit in Critical Access Hospital
- R = Rehabilitation Unit in Critical Access Hospital
- S = Psychiatric unit (excluded from PPS)
- T = Rehabilitation unit (excluded from PPS)
- U = Swing-Bed Hospital Designation for Short-Term Hospitals
- V = Alcohol drug unit (prior to 10/87 only)
- W = Swing-Bed Hospital Designation for Long Term Care Hospitals
- Y = Swing-Bed Hospital Designation for Rehabilitation Hospitals
- Z = Swing Bed Designation for Critical Access Hospitals

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

The sixth position of the provider number is as follows:

- E = Non-federal emergency hospital
- F = Federal emergency hospital

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

If you want additional information about the institutional provider, the quarterly CMS

Provider of Services (POS) file contains dozens of variables that describe the characteristics of the provider. This file is updated quarterly, and effective May 2014 is available for free online from the CMS website (2005-current).

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PRPAY_CD

LABEL: NCH Primary Payer Code (if not Medicare)

DESCRIPTION: The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills. The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.

SHORT NAME: PRPAY_CD

LONG NAME: NCH_PRMRY_PYR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:

- A = Employer group health plan (EGHP) insurance for an aged beneficiary
- B = EGHP insurance for an end-stage renal disease (ESRD) beneficiary
- C = Conditional payment by Medicare; future reimbursement from the Public Health Service (PHS) expected
- D = No fault automobile insurance
- E = Worker's compensation (WC)
- F = Public Health Service (PHS) or other Federal agency (other than VA)
- G = Working disabled beneficiary under age 65 with a local government health plan (LGHP)
- H = Black lung (BL) program
- I = Department of Veteran's Affairs
- L = Any liability insurance
- M = Override EGHP - Medicare is primary payer

N = Override non-EGHP - Medicare is primary payer

Blank/ missing = No other primary payer

COMMENT: -

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PRPAYAMT

LABEL: NCH Primary Payer (if not Medicare) Claim Paid Amount

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

SHORT NAME: PRPAYAMT

LONG NAME: NCH_PRMRY_PYR_CLM_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: DERIVATION RULES: It is calculated as the sum of the line-level primary payer amounts.

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PRSTATE

LABEL: NCH Provider SSA State Code

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

SHORT NAME: PRSTATE

LONG NAME: PRVDR_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

- 00 =Unknown/other
- 01 = Alabama
- 02 = Alaska
- 03 = Arizona
- 04 = Arkansas
- 05 = California
- 06 =Colorado
- 07 = Connecticut
- 08 = Delaware
- 09 = District of Columbia
- 10 = Florida
- 11 = Georgia
- 12 = Hawaii
- 13 = Idaho
- 14 = Illinois
- 15 = Indiana
- 16 = Iowa
- 17 = Kansas
- 18 = Kentucky
- 19 = Louisiana
- 20 = Maine
- 21 = Maryland
- 22 = Massachusetts
- 23 = Michigan

24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = California
56 = Canada & Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
66 = Commonwealth of the Northern Marianas Islands
67 = Texas
68 = Florida (eff. 10/2005)
69 = Florida (eff. 10/2005)
70 = Kansas (eff. 10/2005)

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

COMMENT: -

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PRVDRPMT

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: -

COMMENT: -

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PTB_COIN

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: -

COMMENT: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT

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PTB_DED

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: -

COMMENT: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT

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PTNTRESP

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: CWF

VALUES: -

COMMENT: This 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 OPSS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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PTNTSTUS

LABEL: NCH Patient Status Indicator Code

DESCRIPTION: This variable is a recoded version of the discharge status code (PTNT_DSCHRG_STUS_CD).

SHORT NAME: PTNTSTUS

LONG NAME: NCH_PTNT_STUS_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH QA Process

VALUES: A = Discharged

B = Died

C = Still a patient

COMMENT: -

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QLFYFROM

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:

DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_FROM_DT DERIVATION RULES: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 70. When this code value is present the date is populated using the CLM_SPAN_FROM_DT.

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QLFYTHRU

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:

DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_THRU_DT DERIVATION RULES: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 70. When this code value is present the date is populated using the CLM_SPAN_THRU_DT.

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QUERY_CD

LABEL: Claim Query Code

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

SHORT NAME: QUERY_CD

LONG NAME: CLAIM_QUERY_CODE

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES: 1 = Interim bill

3 = Final bill

5 = Debit adjustment

COMMENT: -

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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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RBENEPMT

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: CWF

VALUES: -

COMMENT: NOTE1: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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RDCDCOIN

LABEL: Revenue Center Reduced Coinsurance Amount

DESCRIPTION: For all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

SHORT NAME: RDCDCOIN

LONG NAME: REV_CNTR_RDCD_COINSRNC_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: NOTE1: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

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REV_CHRG

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.

NOTE: For accommodation revenue center total charges must equal the rate times units (days).

SHORT NAME: REV_CHRG

LONG NAME: REV_CNTR_TOT_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT:

EXCEPTIONS: For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

- (1) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.
- (2) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.
- (3) 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').

- (4) For Inpatient Rehabilitation Facility (IFR) 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.
- (5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

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REV_CNTR

LABEL: Revenue Center Code

DESCRIPTION: The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g.radiology, emergency room, pathology).

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SHORT NAME: REV_CNTR

LONG NAME: REV_CNTR

TYPE: CHAR

LENGTH: 4

SOURCE: CWF

VALUES: 0001 = Total charge

0022 = SNF claim paid under PPS submitted as type of bill (TOB) 21X. NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.

0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).

0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/01). This code may appear only once on a claim.

0100 = All inclusive rate-room and board plus ancillary

0101 = All inclusive rate-room and board

0110 = Private medical or general-general classification

0111 = Private medical or general-medical/surgical/GYN

0112 = Private medical or general-OB

0113 = Private medical or general-pediatric

0114 = Private medical or general-psychiatric

0115 = Private medical or general-hospice

0116 = Private medical or general-detoxification

0117 = Private medical or general-oncology

0118 = Private medical or general-rehabilitation

0119 = Private medical or general-other

0120 = Semi-private 2 bed (medical or general) general classification

0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN

0122 = Semi-private 2 bed (medical or general)-OB

0123 = Semi-private 2 bed (medical or general)-pediatric

0124 = Semi-private 2 bed (medical or general)-psychiatric

0125 = Semi-private 2 bed (medical or general)-hospice

0126 = Semi-private 2 bed (medical or general)-detoxification

0127 = Semi-private 2 bed (medical or general)-oncology

0128 = Semi-private 2 bed (medical or general)-rehabilitation

0129 = Semi-private 2 bed (medical or general)-other

0130 = Semi-private 3 and 4 beds-general classification

0131 = Semi-private 3 and 4 beds-medical/surgical/GYN

0132 = Semi-private 3 and 4 beds-OB

0133 = Semi-private 3 and 4 beds-pediatric

0134 = Semi-private 3 and 4 beds-psychiatric

0135 = Semi-private 3 and 4 beds-hospice

0136 = Semi-private 3 and 4 beds-detoxification

0137 = Semi-private 3 and 4 beds-oncology

0138 = Semi private 3 and 4 beds-rehabilitation

0139 = Semi-private 3 and 4 beds-other

0140 = Private (deluxe)-general classification

0141 = Private (deluxe) medical/surgical/GYN

0142 = Private (deluxe)-OB

0143 = Private (deluxe)-pediatric

0144 = Private (deluxe)-psychiatric

0145 = Private (deluxe)-hospice

0146 = Private (deluxe)-detoxification

0147 = Private (deluxe)-oncology

0148 = Private (deluxe)-rehabilitation

0149 = Private (deluxe)-other

0150 = Room & Board ward (medical or general)-general classification

0151 = Room & Board ward (medical or general)-medical/surgical/GYN

0152 = Room & Board ward (medical or general)-OB

0153 = Room & Board ward (medical or general)-pediatric

0154 = Room & Board ward (medical or general)-psychiatric

0155 = Room & Board ward (medical or general)-hospice

0156 = Room & Board ward (medical or general)-detoxification

0157 = Room & Board ward (medical or general)-oncology

0158 = Room & Board ward (medical or general)-rehabilitation

0159 = Room & Board ward (medical or general)-other

0160 = Other Room & Board-general classification

0164 = Other Room & Board-sterile environment

0167 = Other Room & Board-self care

0169 = Other Room & Board-other

0170 = Nursery-general classification

0171 = Nursery-newborn level I (routine)

0172 = Nursery-premature newborn-level II (continuing care)

0173 = Nursery-newborn-level III (intermediate care)

0174 = Nursery-newborn-level IV (intensive care)

0179 = Nursery-other

0180 = Leave of absence-general classification

0182 = Leave of absence-patient convenience charges billable

0183 = Leave of absence-therapeutic leave

0184 = Leave of absence-ICF mentally retarded-any reason

0185 = Leave of absence-nursing home (hospitalization)

0189 = Leave of absence-other leave of absence

0190 = Subacute care - general classification

0191 = Subacute care - level I

0192 = Subacute care - level II

0193 = Subacute care - level III

0194 = Subacute care - level IV

0199 = Subacute care – other

0200 = Intensive care-general classification

0201 = Intensive care-surgical

0202 = Intensive care-medical

0203 = Intensive care-pediatric

0204 = Intensive care-psychiatric

0206 = Intensive care-post ICU; redefined as intermediate ICU

0207 = Intensive care-burn care

0208 = Intensive care-trauma

0209 = Intensive care-other intensive care

0210 = Coronary care-general classification

0211 = Coronary care-myocardial infraction

0212 = Coronary care-pulmonary care

0213 = Coronary care-heart transplant

0214 = Coronary care-post CCU; redefined as intermediate CCU

0219 = Coronary care-other coronary care

0220 = Special charges-general classification

0221 = Special charges-admission charge

0222 = Special charges-technical support charge

0223 = Special charges-UR service charge

0224 = Special charges-late discharge, medically necessary

0229 = Special charges-other special charges

0230 = Incremental nursing charge rate-general classification

0231 = Incremental nursing charge rate-nursery

0232 = Incremental nursing charge rate-OB

0233 = Incremental nursing charge rate-ICU (include transitional care)

0234 = Incremental nursing charge rate-CCU (include transitional care)

0235 = Incremental nursing charge rate-hospice

0239 = Incremental nursing charge rate-other

0240 = All inclusive ancillary-general classification

0241 = All inclusive ancillary-basic

0242 = All inclusive ancillary-comprehensive

0243 = All inclusive ancillary-specialty

0249 = All inclusive ancillary-other inclusive ancillary

0250 = Pharmacy-general classification

0251 = Pharmacy-generic drugs

0252 = Pharmacy-nongeneric drugs

0253 = Pharmacy-take home drugs

0254 = Pharmacy-drugs incident to other diagnostic service-subject to payment limit

0255 = Pharmacy-drugs incident to radiology-subject to payment limit

0256 = Pharmacy-experimental drugs

0257 = Pharmacy-non-prescription

0258 = Pharmacy-IV solutions

0259 = Pharmacy-other pharmacy

0260 = IV therapy-general classification

0261 = IV therapy-infusion pump

0262 = IV therapy-pharmacy services

0263 = IV therapy-drug supply/delivery

0264 = IV therapy-supplies

0269 = IV therapy-other IV therapy

0270 = Medical/surgical supplies-general classification (also see 062X)

0271 = Medical/surgical supplies-nonsterile supply

0272 = Medical/surgical supplies-sterile supply

0273 = Medical/surgical supplies-take home supplies

0274 = Medical/surgical supplies-prosthetic/orthotic devices

0275 = Medical/surgical supplies-pace maker

0276 = Medical/surgical supplies-intraocular lens

0277 = Medical/surgical supplies-oxygen-take home

0278 = Medical/surgical supplies-other implants

0279 = Medical/surgical supplies-other devices

0280 = Oncology-general classification

0289 = Oncology-other oncology

0290 = DME (other than renal)-general classification

0291 = DME (other than renal)-rental

0292 = DME (other than renal)-purchase of new DME

0293 = DME (other than renal)-purchase of used DME

0294 = DME (other than renal)-related to and listed as DME

0299 = DME (other than renal)-other

0300 = Laboratory-general classification

0301 = Laboratory-chemistry

0302 = Laboratory-immunology

0303 = Laboratory-renal patient (home)

0304 = Laboratory-non-routine dialysis

0305 = Laboratory-hematology

0306 = Laboratory-bacteriology & microbiology

0307 = Laboratory-urology

0309 = Laboratory-other laboratory

0310 = Laboratory pathological-general classification

0311 = Laboratory pathological-cytology

0312 = Laboratory pathological-histology

0314 = Laboratory pathological-biopsy

0319 = Laboratory pathological-other

0320 = Radiology diagnostic-general classification

0321 = Radiology diagnostic-angiocardiology

0322 = Radiology diagnostic-arthrography

0323 = Radiology diagnostic-arteriography

0324 = Radiology diagnostic-chest X-ray

0329 = Radiology diagnostic-other

0330 = Radiology therapeutic-general classification

0331 = Radiology therapeutic-chemotherapy injected

0332 = Radiology therapeutic-chemotherapy oral

0333 = Radiology therapeutic-radiation therapy

0335 = Radiology therapeutic-chemotherapy IV

0339 = Radiology therapeutic-other

0340 = Nuclear medicine-general classification

0341 = Nuclear medicine-diagnostic

0342 = Nuclear medicine-therapeutic

0349 = Nuclear medicine-other

0350 = Computed tomographic (CT) scan-general classification

0351 = CT scan-head scan

0352 = CT scan-body scan

0359 = CT scan-other CT scans

0360 = Operating room services-general classification

0361 = Operating room services-minor surgery

0362 = Operating room services-organ transplant, other than kidney

0367 = Operating room services-kidney transplant

0369 = Operating room services-other operating room services

0370 = Anesthesia-general classification

0371 = Anesthesia-incident to RAD and subject to the payment limit

0372 = Anesthesia-incident to other diagnostic service and subject to the payment limit

0374 = Anesthesia-acupuncture

0379 = Anesthesia-other anesthesia

0380 = Blood-general classification

0381 = Blood-packed red cells

0382 = Blood-whole blood

0383 = Blood-plasma

0384 = Blood-platelets

0385 = Blood-leukocytes

0386 = Blood-other components

0387 = Blood-other derivatives (cryoprecipitates)

0389 = Blood-other blood

0390 = Blood storage and processing-general classification

 0391 = Blood storage and processing-blood administration

 0399 = Blood storage and processing-other

0400 = Other imaging services-general classification

0401 = Other imaging services-diagnostic mammography

 0402 = Other imaging services-ultrasound

 0403 = Other imaging services-screening mammography

 0404 = Other imaging services-positron emission tomography

0409 = Other imaging services-other

0410 = Respiratory services-general classification

 0412 = Respiratory services-inhalation services

 0413 = Respiratory services-hyperbaric oxygen therapy

 0419 = Respiratory services-other

0420 = Physical therapy-general classification

 0421 = Physical therapy-visit charge

 0422 = Physical therapy-hourly charge

 0423 = Physical therapy-group rate

 0424 = Physical therapy-evaluation or re-evaluation

 0429 = Physical therapy-other

0430 = Occupational therapy-general classification

0431 = Occupational therapy-visit charge

0432 = Occupational therapy-hourly charge

0433 = Occupational therapy-group rate

0434 = Occupational therapy-evaluation or re-evaluation

0439 = Occupational therapy-other (may include restorative therapy)

0440 = Speech language pathology-general classification

0441 = Speech language pathology-visit charge

0442 = Speech language pathology-hourly charge

0443 = Speech language pathology-group rate

0444 = Speech language pathology-evaluation or re-evaluation

0449 = Speech language pathology-other

0450 = Emergency room-general classification

0451 = Emergency room-emptala emergency medical screening services

0452 = Emergency room-ER beyond emptala screening

0456 = Emergency room-urgent care

0459 = Emergency room-other

0460 = Pulmonary function-general classification

0469 = Pulmonary function-other

0470 = Audiology-general classification

0471 = Audiology-diagnostic

0472 = Audiology-treatment

0479 = Audiology-other

0480 = Cardiology-general classification

0481 = Cardiology-cardiac cath lab

0482 = Cardiology-stress test

0483 = Cardiology-Echocardiology

0489 = Cardiology-other

0490 = Ambulatory surgical care-general classification

0499 = Ambulatory surgical care-other

0500 = Outpatient services-general classification

0509 = Outpatient services-other

0510 = Clinic-general classification

0511 = Clinic-chronic pain center

0512 = Clinic-dental center

0513 = Clinic-psychiatric

0514 = Clinic-OB-GYN

0515 = Clinic-pediatric

0516 = Clinic-urgent care clinic

0517 = Clinic-family practice clinic

0519 = Clinic-other

0520 = Free-standing clinic-general classification

0521 = Free-standing clinic-Clinic visit by a member to RHC/FQHC (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Clinic

0522 = Free-standing clinic-Home visit by RHC/FQHC practitioner (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Home

0523 = Free-standing clinic-family practice

0524 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF. (eff. 7/1/06)

0525 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/06)

0526 = Free-standing clinic-urgent care (eff 10/96)

0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/06)

0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)

0529 = Free-standing clinic-other

0530 = Osteopathic services-general classification

0531 = Osteopathic services-osteopathic therapy

0539 = Osteopathic services-other

0540 = Ambulance-general classification

0541 = Ambulance-supplies

0542 = Ambulance-medical transport

0543 = Ambulance-heart mobile

0544 = Ambulance-oxygen

0545 = Ambulance-air ambulance

0546 = Ambulance-neo-natal ambulance

0547 = Ambulance-pharmacy

0548 = Ambulance-telephone transmission EKG

0549 = Ambulance-other

0550 = Skilled nursing-general classification

0551 =Skilled nursing-visit charge

0552 =Skilled nursing-hourly charge

0559 =Skilled nursing-other

0560 =Medical social services-general classification

0561 =Medical social services-visit charge

0562 =Medical social services-hourly charges

0569 =Medical social services-other

0570 =Home health aid (home health)-general classification

0571 =Home health aid (home health)-visit charge

0572 =Home health aid (home health)-hourly charge

0579 =Home health aid (home health)-other

0580 =Other visits (home health)-general classification
(under HHPPS, not allowed as covered charges)

0581 = Other visits (home health)-visit charge (under HHPPS, not allowed as covered charges)

0582 = Other visits (home health)-hourly charge (under HHPPS, not allowed as covered charges)

0589 = Other visits (home health)-other (under HHPPS, not allowed as covered charges)

0590 = Units of service (home health)-general classification (under HHPPS, not allowed as covered charges)

0599 = Units of service (home health)-other (under HHPPS, not allowed as covered charges)

0600 = Oxygen/Home Health-general classification

0601 = Oxygen/Home Health-stat or port equip/supply or count

0602 = Oxygen/Home Health-stat/equip/under 1 LPM

0603 = Oxygen/Home Health-stat/equip/over 4 LPM

0604 = Oxygen/Home Health-stat/equip/portable add-on

0610 = Magnetic resonance technology (MRT)-general classification

0611 = MRT/MRI-brain (including brainstem)

0612 = MRT/MRI-spinal cord (including spine)

0614 = MRT/MRI-other

0615 = MRT/MRA-Head and Neck

0616 = MRT/MRA-Lower Extremities

0618 = MRT/MRA-other

0619 = MRT/Other MRI

0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit - extension of 027X

0622 = Medical/surgical supplies-incident to other diagnostic service- subject to the payment limit - extension of 027X

0623 = Medical/surgical supplies-surgical dressings - extension of 027X

0624 = Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE's - extension of 027X

0630 = Reserved

0631 = Drugs requiring specific identification-single drug source

0632 = Drugs requiring specific identification-multiple drug source

0633 = Drugs requiring specific identification-restrictive prescription

0634 = Drugs requiring specific identification-EPO under 10,000 units

0635 = Drugs requiring specific identification-EPO 10,000 units or more

0636 = Drugs requiring specific identification-detailed coding

0637 = Self-administered drugs administered in an emergency situation - not requiring detailed coding

0640 = Home IV therapy-general classification

0641 = Home IV therapy-nonroutine nursing

0642 = Home IV therapy-IV site care, central line

0643 = Home IV therapy-IV start/change peripheral line

0644 = Home IV therapy-nonroutine nursing, peripheral line

0645 = Home IV therapy-train patient/caregiver, central line

0646 = Home IV therapy-train disabled patient, central line

0647 = Home IV therapy-train patient/caregiver, peripheral line

0648 = Home IV therapy-train disabled patient, peripheral line

0649 = Home IV therapy-other IV therapy services

0650 = Hospice services-general classification

0651 = Hospice services-routine home care

0652 = Hospice services-continuous home care-1/2

0655 = Hospice services-inpatient care

0656 = Hospice services-general inpatient care (non-respite)

0657 = Hospice services-physician services

0659 = Hospice services-other

0660 = Respite care (HHA)-general classification

0661 = Respite care (HHA)-hourly charge/skilled nursing

0662 = Respite care (HHA)-hourly charge/home health aide/homemaker

0670 = OP special residence charges - general classification

0671 = OP special residence charges - hospital based

0672 = OP special residence charges –
contracted

0679 = OP special residence charges - other special residence charges

0700 = Cast room-general classification

0709 = Cast room-other

0710 = Recovery room-general classification

0719 = Recovery room-other

0720 = Labor room/delivery-general classification

0721 = Labor room/delivery-labor

0722 = Labor room/delivery-delivery

0723 = Labor room/delivery-circumcision

0724 = Labor room/delivery-birthing center

0729 = Labor room/delivery-other

0730 = EKG/ECG-general classification

0731 = EKG/ECG-Holter monitor

0732 = EKG/ECG-telemetry

0739 = EKG/ECG-other

0740 = EEG-general classification

0749 = EEG (electroencephalogram)-other

0750 = Gastro-intestinal services-general classification

0759 = Gastro-intestinal services-other

0760 = Treatment or observation room-general classification

0761 = Treatment or observation room-treatment room

0762 = Treatment or observation room-observation room

0769 = Treatment or observation room-other

0770 = Preventative care services-general classification

0771 = Preventative care services-vaccine administration

0779 = Preventative care services-other

0780 = Telemedicine - general classification

0789 = Telemedicine – telemedicine

0790 = Lithotripsy-general classification

0799 = Lithotripsy-other

0800 = Inpatient renal dialysis-general classification

0801 = Inpatient renal dialysis-inpatient hemodialysis

0802 = Inpatient renal dialysis-inpatient peritoneal (non-CAPD)

0803 = Inpatient renal dialysis-inpatient CAPD

0804 = Inpatient renal dialysis-inpatient CCPD

0809 = Inpatient renal dialysis-other inpatient dialysis

0810 = Organ acquisition-general classification

0811 = Organ acquisition-living donor

0812 = Organ acquisition-cadaver donor

0813 = Organ acquisition-unknown donor

0814 = Organ acquisition - unsuccessful organ search-donor bank charges

0819 = Organ acquisition-other donor

0820 = Hemodialysis OP or home dialysis-general classification

0821 = Hemodialysis OP or home dialysis-hemodialysis-composite or other rate

0822 = Hemodialysis OP or home dialysis-home supplies

0823 = Hemodialysis OP or home dialysis-home equipment

0824 = Hemodialysis OP or home dialysis-maintenance/100%

0825 = Hemodialysis OP or home dialysis-support services

0829 = Hemodialysis OP or home dialysis-other

0830 = Peritoneal dialysis OP or home-general classification

0831 = Peritoneal dialysis OP or home-peritoneal-composite or other rate

0832 = Peritoneal dialysis OP or home-home supplies

0833 = Peritoneal dialysis OP or home-home equipment

0834 = Peritoneal dialysis OP or home-maintenance/100%

0835 = Peritoneal dialysis OP or home-support services

0839 = Peritoneal dialysis OP or home-other

0840 = CAPD outpatient-general classification

0841 = CAPD outpatient-CAPD/composite or other rate

0842 = CAPD outpatient-home supplies

0843 = CAPD outpatient-home equipment

0844 = CAPD outpatient-maintenance/100%

0845 = CAPD outpatient-support services

0849 = CAPD outpatient-other

0850 = CCPD outpatient-general classification

0851 = CCPD outpatient-CCPD/composite or other rate

0852 = CCPD outpatient-home supplies

0853 = CCPD outpatient-home equipment

0854 = CCPD outpatient-maintenance/100%

0855 = CCPD outpatient-support services

0859 = CCPD outpatient-other

0880 = Miscellaneous dialysis-general classification

0881 = Miscellaneous dialysis-ultrafiltration

0882 = Miscellaneous dialysis-home dialysis aide visit

0889 = Miscellaneous dialysis-other

0890 = Other donor bank-general classification; changed to reserved for national assignment

0891 = Other donor bank-bone; changed to reserved for national assignment

0892 = Other donor bank-organ (other than kidney); changed to reserved for national assignment

0893 = Other donor bank-skin; changed to reserved for national assignment

0899 = Other donor bank-other; changed to reserved for national assignment

0900 = Behavior Health Treatment/Services - general classification (eff. 10/2004); prior to 10/2004 defined as Psychiatric/ psychological treatments-general classification

0901 = Behavior Health Treatment/Services – electroshock treatment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/ psychological treatments-electroshock treatment

0902 = Behavior Health Treatment/Services - milieu therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-milieu therapy

0903 = Behavior Health Treatment/Services - play therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments- play therapy

0904 = Behavior Health Treatment/Services - activity therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments- activity therapy

- 0905 = Behavior Health Treatment/Services - intensive outpatient services- psychiatric (eff. 10/2004)
- 0906 = Behavior Health Treatment/Services - intensive outpatient services- chemical dependency (eff. 10/2004)
- 0907 = Behavior Health Treatment/Services - community behavioral health program-day treatment (eff. 10/2004)
- 0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-other
- 0910 = Behavioral Health Treatment/Services-Reserved for National Assignment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-general classification
- 0911 = Behavioral Health Treatment/Services-rehabilitation (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services- rehabilitation
- 0912 = Behavioral Health Treatment/Services-partial hospitalization-less intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/ psychological services-less intensive
- 0913 = Behavioral Health Treatment/Services-partial hospitalization- intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/ psychological services-intensive
- 0914 = Behavioral Health Treatment/Services-individual therapy (eff. 10/2004) prior to 10/2004 defined as Psychiatric/psychological services- individual therapy
- 0915 = Behavioral Health Treatment/Services-group therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services- group therapy
- 0916 = Behavioral Health Treatment/Services-family therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-family therapy
- 0917 = Behavioral Health Treatment/Services-biofeedback (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services- biofeedback
- 0918 = Behavioral Health Treatment/Services-testing (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-testing

- 0919 = Behavioral Health Treatment/Services-other (eff. 10/2004);
prior to 10/2004 defined as Psychiatric/psychological
services-other
- 0920 = Other diagnostic services-general classification
- 0921 = Other diagnostic services-peripheral vascular lab
- 0922 = Other diagnostic services-electromyogram
- 0923 = Other diagnostic services-pap smear
- 0924 = Other diagnostic services-allergy test
- 0925 = Other diagnostic services-pregnancy test
- 0929 = Other diagnostic services-other
- 0931 = Medical Rehabilitation Day Program - Half Day
- 0932 = Medical Rehabilitation Day Program - Full Day
- 0940 = Other therapeutic services-general classification
- 0941 = Other therapeutic services-recreational therapy
- 0942 = Other therapeutic services-education/training (include
diabetes diet training)
- 0943 = Other therapeutic services-cardiac rehabilitation
- 0944 = Other therapeutic services-drug rehabilitation
- 0945 = Other therapeutic services-alcohol rehabilitation
- 0946 = Other therapeutic services-routine complex medical
equipment
- 0947 = Other therapeutic services-ancillary complex medical
equipment
- 0949 = Other therapeutic services-other
- 0951 = Professional Fees-athletic training (extension of 094X)
- 0952 = Professional Fees-kinesiotherapy (extension of 094X)

0960 = Professional fees-general classification

0961 = Professional fees-psychiatric

0962 = Professional fees-ophthalmology

0963 = Professional fees-anesthesiologist (MD)

0964 = Professional fees-anesthetist (CRNA)

0969 = Professional fees-other NOTE: 097X is an extension of 096X

0971 = Professional fees-laboratory

0972 = Professional fees-radiology diagnostic

0973 = Professional fees-radiology therapeutic

0974 = Professional fees-nuclear medicine

0975 = Professional fees-operating room

0976 = Professional fees-respiratory therapy

0977 = Professional fees-physical therapy

0978 = Professional fees-occupational therapy

0979 = Professional fees-speech pathology NOTE: 098X is an extension of 096X & 097X

0981 = Professional fees-emergency room

0982 = Professional fees-outpatient services

0983 = Professional fees-clinic

0984 = Professional fees-medical social services

0985 = Professional fees-EKG

0986 = Professional fees-EEG

0987 = Professional fees-hospital visit

0988 = Professional fees-consultation

0989 = Professional fees-private duty nurse

0990 = Patient convenience items-general classification

0991 = Patient convenience items-cafeteria/guest tray

0992 = Patient convenience items-private linen service

0993 = Patient convenience items-telephone/telegraph

0994 = Patient convenience items-tv/radio

0995 = Patient convenience items-nonpatient room rentals

0996 = Patient convenience items-late discharge charge

0997 = Patient convenience items-admission kits

0998 = Patient convenience items-beauty shop/barber

0999 = Patient convenience items-other

NOTE: Following Revenue Codes reported for NHCMQ (RUGS) demo claims effective 2/96.

9000 = RUGS-no MDS assessment available

9001 = Reduced physical functions-RUGS PA1/ADL index of 4-5

9002 = Reduced physical functions-RUGS PA2/ADL index of 4-5

9003 = Reduced physical functions-RUGS PB1/ADL index of 6-8

9004 = Reduced physical functions-RUGS PB2/ADL index of 6-8

9005 = Reduced physical functions-RUGS PC1/ADL index of 9-10

9006 = Reduced physical functions-RUGS PC2/ADL index of 9-10

9007 = Reduced physical functions-RUGS PD1/ADL index of 11-15

9008 = Reduced physical functions-RUGS PD2/ADL index of 11-15

9009 = Reduced physical functions-RUGS PE1/ADL index of 16-18

9010 = Reduced physical functions-RUGS PE2/ADL index of 16-18

9011 = Behavior only problems-RUGS BA1/ADL index of 4-5

9012 = Behavior only problems-RUGS BA2/ADL index of 4-5

9013 = Behavior only problems-RUGS BB1/ADL index of 6-10

9014 = Behavior only problems-RUGS BB2/ADL index of 6-10

9015 = Impaired cognition-RUGS IA1/ADL index of 4-5

9016 = Impaired cognition-RUGS IA2/ADL index of 4-5

9017 = Impaired cognition-RUGS IB1/ADL index of 6-10

9018 = Impaired cognition-RUGS IB2/ADL index of 6-10

9019 = Clinically complex-RUGS CA1/ADL index of 4-5

9020 = Clinically complex-RUGS CA2/ADL index of 4-5d

9021 = Clinically complex-RUGS CB1/ADL index of 6-10

9022 = Clinically complex-RUGS CB2/ADL index of 6-10d

9023 = Clinically complex-RUGS CC1/ADL index of 11-16

9024 = Clinically complex-RUGS CC2/ADL index of 11-16d

9025 = Clinically complex-RUGS CD1/ADL index of 17-18

9026 = Clinically complex-RUGS CD2/ADL index of 17-18d

9027 = Special care-RUGS SSA/ADL index of 7-13

9028 = Special care-RUGS SSB/ADL index of 14-16

9029 = Special care-RUGS SSC/ADL index of 17-18

9030 = Extensive services-RUGS SE1/1 procedure

9031 = Extensive services-RUGS SE2/2 procedures

9032 = Extensive services-RUGS SE3/3 procedures

9033 = Low rehabilitation-RUGS RLA/ADL index of 4-11

9034 = Low rehabilitation-RUGS RLB/ADL index of 12-18

9035 = Medium rehabilitation-RUGS RMA/ADL index of 4-7

9036 = Medium rehabilitation-RUGS RMB/ADL index of 8-15

9037 = Medium rehabilitation-RUGS RMC/ADL index of 16-18

9038 = High rehabilitation-RUGS RHA/ADL index of 4-7

9039 = High rehabilitation-RUGS RHB/ADL index of 8-11

9040 = High rehabilitation-RUGS RHC/ADL index of 12-14

9041 = High rehabilitation-RUGS RHD/ADL index of 15-18

9042 = Very high rehabilitation-RUGS RVA/ADL index of 4-7

9043 = Very high rehabilitation-RUGS RVB/ADL index of 8-13

9044 = Very high rehabilitation-RUGS RVC/ADL index of 14-18

Changes effective for providers entering

RUGS Demo Phase III as of 1/1/97 or later

9019 = Clinically complex-RUGS CA1/ADL index of 11

9020 = Clinically complex-RUGS CA2/ADL index of 11D

9021 = Clinically complex-RUGS CB1/ADL index of 12-16

9022 = Clinically complex-RUGS CB2/ADL index of 12-16D

9023 = Clinically complex-RUGS CC1/ADL index of 17-18

9024 = Clinically complex-RUGS CC2/ADL index of 17-18D

9025 = Special care-RUGS SSA/ADL index of 14

9026 = Special care-RUGS SSB/ADL index of 15-16

9027 = Special care-RUGS SSC/ADL index of 17-18

9028 = Extensive services-RUGS SE1/ADL index 7-18/1 procedure

9029 = Extensive services-RUGS SE2/ADL index 7-18/2 procedures

9030 = Extensive services-RUGS SE3/ADL index 7-18/3 procedures

9031 = Low rehabilitation-RUGS RLA/ADL index of 4-13

9032 = Low rehabilitation-RUGS RLB/ADL index of 14-18

9033 = Low rehabilitation-RUGS RLA/ADL index of 4-11

9034 = Medium rehabilitation-RUGS RMB/ADL index of 8-14

9035 = Medium rehabilitation-RUGS RMC/ADL index of 15-18

9036 = High rehabilitation-RUGS RHA/ADL index of 4-7

9037 = High rehabilitation-RUGS RHB/ADL index of 8-12

9038 = High rehabilitation-RUGS RHC/ADL index of 13-18

9039 = Very High rehabilitation-RUGS RVA/ADL index of 4-8

9040 = Very high rehabilitation-RUGS RVB/ADL index of 9-15

9041 = Very high rehabilitation-RUGS RVC/ADL index of 16

9042 = Very high rehabilitation-RUGS RUA/ADL index of 4-8

9043 = Very high rehabilitation-RUGS RUB/ADL index of 9-15

9044 = Ultra high rehabilitation-RUGS RUC/ADL index of 16-18

COMMENT: -

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REV_CNTR_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: -

VALUES: -

COMMENT: -

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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: -

VALUES: F2 = International Unit

GR = Gram

ML = Milliliter

UN = Unit

COMMENT: -

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REV_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: CCW

VALUES: -

COMMENT: -

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REV_MSP1

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: CWF

VALUES: -

COMMENT: NOTE1: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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REV_MSP2

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: CWF

VALUES: -

COMMENT: NOTE1: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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REV_NCVR

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: CWF

VALUES: -

COMMENT: -

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REV_RATE

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: CWF

VALUES: -

COMMENT: NOTE1: 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).

NOTE2: 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.

NOTE3: 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.

NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field). Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

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REV_UNIT

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: CWF

VALUES: -

COMMENT: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

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REVANSI1

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). NOTE: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward. Valid beginning with NCH weekly process date 7/7/00.

SHORT NAME: REVANSI1

LONG NAME: REV_CNTR_1ST_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES:

*****EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*****
*****POSITIONS 1 & 2 OF ANSI CODE*****

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies

when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment. PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

*****Claim Adjustment Reason Codes*****
*****POSITIONS 3 through 5 of ANSI CODE*****

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = The date of death precedes the date of service.

- 14 = The date of birth follows the date of service.
- 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 16 = Claim/service lacks information which is needed for adjudication.
- 17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
- 18 = Duplicate claim/service.
- 19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
- 20 = Claim denied because this injury/illness is covered by the liability carrier.
- 21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
- 22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
- 23 = Claim adjusted because charges have been paid by another payer.
- 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 25 = Payment denied. Your Stop loss deductible has not been met.
- 26 = Expenses incurred prior to coverage.
- 27 = Expenses incurred after coverage terminated.
- 28 = Coverage not in effect at the time the service was provided.
- 29 = The time limit for filing has expired.
- 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
- 31 = Claim denied as patient cannot be identified as our insured.
- 32 = Our records indicate that this dependent is not an eligible dependent as defined.

- 33 = Claim denied. Insured has no dependent coverage.
- 34 = Claim denied. Insured has no coverage for newborns.
- 35 = Benefit maximum has been reached.
- 36 = Balance does not exceed copayment amount.
- 37 = Balance does not exceed deductible amount.
- 38 = Services not provided or authorized by designated (network) providers.
- 39 = Services denied at the time authorization/pre-certification was requested.
- 40 = Charges do not meet qualifications for emergency/urgent care.
- 41 = Discount agreed to in Preferred Provider contract.
- 42 = Charges exceed our fee schedule or maximum allowable amount.
- 43 =Gramm-Rudman reduction.
- 44 = Prompt-pay discount.
- 45 = Charges exceed your contracted/legislated fee arrangement.
- 46 = This (these) service(s) is (are) not covered.
- 47 = This (these) diagnosis (es) is (are) not covered, missing, or are invalid.
- 48 = This (these) procedure(s) is (are) not covered.
- 49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 51 = These are non-covered services because this a pre-existing condition.
- 52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
- 53 = Services by an immediate relative or a member of the same household are not covered.

- 54 = Multiple physicians/assistants are not covered in this case.
- 55 = Claim/service denied because procedure/treatment is deemed Experimental/investigational by the payer.
- 56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
- 57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
- 58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- 59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 60 = Charges for outpatient services with the proximity to inpatient services are not covered.
- 61 = Charges adjusted as penalty for failure to obtain second surgical opinion.
- 62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.
- 63 = Correction to a prior claim. INACTIVE
- 64 = Denial reversed per Medical Review. INACTIVE
- 65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
- 66 = Blood Deductible.
- 67 = Lifetime reserve days. INACTIVE
- 68 = DRG weight. INACTIVE
- 69 = Day outlier amount.
- 70 = Cost outlier amount.
- 71 = Primary Payer amount.
- 72 = Coinsurance day. INACTIVE
- 73 = Administrative days. INACTIVE

- 74 = Indirect Medical Education Adjustment.
- 75 = Direct Medical Education Adjustment.
- 76 = Disproportionate Share Adjustment.
- 77 = Covered days. INACTIVE
- 78 = Non-covered days/room charge adjustment.
- 79 = Cost report days. INACTIVE
- 80 = Outlier days. INACTIVE
- 81 = Discharges. INACTIVE
- 82 = PIP days. INACTIVE
- 83 = Total visits. INACTIVE
- 84 = Capital adjustments. INACTIVE
- 85 = Interest amount. INACTIVE
- 86 = Statutory adjustment. INACTIVE
- 87 = Transfer amounts.
- 88 = Adjustment amount represents collection against receivable created in prior overpayment.
- 89 = Professional fees removed from charges.
- 90 = Ingredient cost adjustment.
- 91 = Dispensing fee adjustment.
- 92 = Claim paid in full. INACTIVE
- 93 = No claim level adjustment. INACTIVE
- 94 = Process in excess of charges.
- 95 = Benefits adjusted. Plan procedures not followed.
- 96 = Non-covered charges.
- 97 = Payment is included in allowance for another service/procedure.
- 98 = The hospital must file the Medicare claim for this inpatient non-

physician service. INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party.

101 = Predetermination: anticipated payment upon completion of services or claim adjudication.

102 = Major medical adjustment.

103 = Provider promotional discount (i.e. Senior citizen discount).

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/ service was not paid or identified on the claim.

108 = Claim/service reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/Product not approved by the Food and Drug Administration.

115 = Claim/service adjusted as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

- 119 = Benefit maximum for this time period has been reached.
- 120 = Patient is covered by a managed care plan. INACTIVE
- 121 = Indemnification adjustment.
- 122 = Psychiatric reduction.
- 123 = Payer refund due to overpayment. INACTIVE
- 124 = Payer refund amount - not our patient. INACTIVE
- 125 = Claim/service adjusted due to a submission/billing error(s).
- 126 = Deductible - Major Medical.
- 127 = Coinsurance - Major Medical.
- 128 = Newborn's services are covered in the mother's allowance.
- 129 = Claim denied - prior processing information appears incorrect.
- 130 = Paper claim submission fee.
- 131 = Claim specific negotiated discount.
- 132 = Prearranged demonstration project adjustment.
- 133 = The disposition of this claim/service is pending further review.
- 134 = Technical fees removed from charges.
- 135 = Claim denied. Interim bills cannot be processed.
- 136 = Claim adjusted. Plan procedures of a prior payer were not followed.
- 137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
- 138 = Claim/service denied. Appeal procedures not followed or time limits not met.
- 139 = Contracted funding agreement - subscriber is employed by the provider of services.
- 140 = Patient/Insured health identification number and name do not match.
- 141 = Claim adjustment because the claim spans eligible and ineligible

periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount.

A6 = Prior hospitalization or 30 day transfer requirement not met.

A7 = Presumptive Payment Adjustment.

A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/

processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

COMMENT: -

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REVANSI2

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).

NOTE: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward. Valid beginning with NCH weekly process date 7/7/00.

SHORT NAME: REVANSI2

LONG NAME: REV_CNTR_2ND_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES:

*****EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*****
*****POSITIONS 1 & 2 OF ANSI CODE*****

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

- OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.
- PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).
- PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

*****Claim Adjustment Reason Codes*****
 *****POSITIONS 3 through 5 of ANSI CODE*****

- 1 = Deductible Amount
- 2 = Coinsurance Amount
- 3 = Co-pay Amount
- 4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 5 = The procedure code/bill type is inconsistent with the place of service.
- 6 = The procedure code is inconsistent with the patient's age.
- 7 = The procedure code is inconsistent with the patient's gender.
- 8 = The procedure code is inconsistent with the provider type.
- 9 = The diagnosis is inconsistent with the patient's age.
- 10 = The diagnosis is inconsistent with the patient's gender.
- 11 = The diagnosis is inconsistent with the procedure.

- 12 = The diagnosis is inconsistent with the provider type.
- 13 = The date of death precedes the date of service.
- 14 = The date of birth follows the date of service.
- 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 16 = Claim/service lacks information which is needed for adjudication.
- 17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
- 18 = Duplicate claim/service.
- 19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
- 20 = Claim denied because this injury/illness is covered by the liability carrier.
- 21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
- 22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
- 23 = Claim adjusted because charges have been paid by another payer.
- 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 25 = Payment denied. Your Stop loss deductible has not been met.
- 26 = Expenses incurred prior to coverage.
- 27 = Expenses incurred after coverage terminated.
- 28 = Coverage not in effect at the time the service was provided.
- 29 = The time limit for filing has expired.

- 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
- 31 = Claim denied as patient cannot be identified as our insured.
- 32 = Our records indicate that this dependent is not an eligible dependent as defined.
- 33 = Claim denied. Insured has no dependent coverage.
- 34 = Claim denied. Insured has no coverage for newborns.
- 35 = Benefit maximum has been reached.
- 36 = Balance does not exceed copayment amount.
- 37 = Balance does not exceed deductible amount.
- 38 = Services not provided or authorized by designated (network) providers.
- 39 = Services denied at the time authorization/pre-certification was requested.
- 40 = Charges do not meet qualifications for emergency/urgent care.
- 41 = Discount agreed to in Preferred Provider contract.
- 42 = Charges exceed our fee schedule or maximum allowable amount.
- 43 = Gramm-Rudman reduction.
- 44 = Prompt-pay discount.
- 45 = Charges exceed your contracted/legislated fee arrangement.
- 46 = This (these) service(s) is (are) not covered.
- 47 = This (these) diagnosis (es) is (are) not covered, missing, or are invalid.

- 48 = This (these) procedure(s) is(are) not covered.
- 49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 51 = These are non-covered services because this a pre-existing condition.
- 52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
- 53 = Services by an immediate relative or a member of the same household are not covered.
- 54 = Multiple physicians/assistants are not covered in this case.
- 55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
- 56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
- 57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
- 58 = Claim/service adjusted because treatment was deemed by the payer

to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education

Adjustment.

- 75 = Direct Medical Education Adjustment.
- 76 = Disproportionate Share Adjustment.
- 77 = Covered days. INACTIVE
- 78 = Non-covered days/room charge adjustment.
- 79 = Cost report days. INACTIVE
- 80 = Outlier days. INACTIVE
- 81 = Discharges. INACTIVE
- 82 = PIP days. INACTIVE
- 83 = Total visits. INACTIVE
- 84 = Capital adjustments. INACTIVE
- 85 = Interest amount. INACTIVE
- 86 = Statutory adjustment. INACTIVE
- 87 = Transfer amounts.
- 88 = Adjustment amount represents collection against receivable created in prior overpayment.
- 89 = Professional fees removed from charges.
- 90 = Ingredient cost adjustment.
- 91 = Dispensing fee adjustment.
- 92 = Claim paid in full. INACTIVE
- 93 = No claim level adjustment. INACTIVE
- 94 = Process in excess of charges.

95 = Benefits adjusted. Plan procedures not followed.

96 = Non-covered charges.

97 = Payment is included in allowance for another service/procedure.

98 = The hospital must file the Medicare claim for this inpatient non-physician service.

INACTIVE

99 = Medicare Secondary Payer Adjustment Amount. INACTIVE

100 = Payment made to patient/insured/responsible party.

101 = Predetermination: anticipated payment upon completion of services or claim adjudication.

102 = Major medical adjustment.

103 = Provider promotional discount (i.e. Senior citizen discount).

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/ service was not paid or identified on the claim.

108 = Claim/service reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/PRODUCT not approved by the Food and Drug Administration.

- 115 = Claim/service adjusted as procedure postponed or canceled.
- 116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
- 117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.
- 118 = Charges reduced for ESRD network support.
- 119 = Benefit maximum for this time period has been reached.
- 120 = Patient is covered by a managed care plan. INACTIVE
- 121 = Indemnification adjustment.
- 122 = Psychiatric reduction.
- 123 = Payer refund due to overpayment. INACTIVE
- 124 = Payer refund amount - not our patient. INACTIVE
- 125 = Claim/service adjusted due to a submission/billing error(s). 126 = Deductible - Major Medical.
- 127 = Coinsurance - Major Medical.
- 128 = Newborn's services are covered in the mother's allowance.
- 129 = Claim denied - prior processing information appears incorrect.
- 130 = Paper claim submission fee.
- 131 = Claim specific negotiated discount.
- 132 = Prearranged demonstration project adjustment.
- 133 = The disposition of this claim/service is pending further review.
- 134 = Technical fees removed from charges.
- 135 = Claim denied. Interim bills cannot be processed.

- 136 = Claim adjusted. Plan procedures of a prior payer were not followed.
- 137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
- 138 = Claim/service denied. Appeal procedures not followed or time limits not met.
- 139 = Contracted funding agreement - subscriber is employed by the provider of services.
- 140 = Patient/Insured health identification number and name do not match.
- 141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
- 142 = Claim adjusted by the monthly Medicaid patient liability amount.
- A0 = Patient refund amount
- A1 = Claim denied charges.
- A2 = Contractual adjustment.
- A3 = Medicare Secondary Payer liability met. INACTIVE
- A4 = Medicare Claim PPS Capital Day Outlier Amount.
- A5 = Medicare Claim PPS Capital Cost Outlier Amount.
- A6 = Prior hospitalization or 30 day transfer requirement not met.
- A7 = Presumptive Payment Adjustment.
- A8 = Claim denied; ungroupable DRG.
- B1 = Non-covered visits.
- B2 = Covered visits. INACTIVE
- B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/ processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

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REVANSI3

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).

NOTE: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward. Valid beginning with NCH weekly process date 7/7/00.

SHORT NAME: REVANSI3

LONG NAME: REV_CNTR_3RD_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES:

*****EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*****
*****POSITIONS 1 & 2 OF ANSI CODE*****

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA =Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or

professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

*****Claim Adjustment Reason Codes*****
*****POSITIONS 3 through 5 of ANSI CODE*****

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = The date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed

services or provider.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 = Claim denied because this injury/illness is covered by the liability carrier.

21 = Claim denied because this injury/illness is the liability of the no-fault carrier.

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer. 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

25 = Payment denied. Your Stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.

29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.

37 = Balance does not exceed deductible amount.

- 38 = Services not provided or authorized by designated (network) providers.
- 39 = Services denied at the time authorization/pre-certification was requested.
- 40 = Charges do not meet qualifications for emergency/urgent care.
- 41 = Discount agreed to in Preferred Provider contract.
- 42 = Charges exceed our fee schedule or maximum allowable amount.
- 43 = Gramm-Rudman reduction.
- 44 = Prompt-pay discount.
- 45 = Charges exceed your contracted/legislated fee arrangement.
- 46 = This (these) service(s) is (are) not covered.
- 47 = This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
- 48 = This (these) procedure(s) is (are) not covered.
- 49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 51 = These are non-covered services because this a pre-existing condition.
- 52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
- 53 = Services by an immediate relative or a member of the same household are not covered.
- 54 = Multiple physicians/assistants are not covered in this case.
- 55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
- 56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
- 57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
- 58 = Claim/service adjusted because treatment was deemed by the payer

to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

- 81 = Discharges. INACTIVE
- 82 = PIP days. INACTIVE
- 83 = Total visits. INACTIVE
- 84 = Capital adjustments. INACTIVE
- 85 = Interest amount. INACTIVE
- 86 = Statutory adjustment. INACTIVE
- 87 = Transfer amounts.
- 88 = Adjustment amount represents collection against receivable created in prior overpayment.
- 89 = Professional fees removed from charges.
- 90 = Ingredient cost adjustment.
- 91 = Dispensing fee adjustment.
- 92 = Claim paid in full. INACTIVE
- 93 = No claim level adjustment. INACTIVE
- 94 = Process in excess of charges.
- 95 = Benefits adjusted. Plan procedures not followed.
- 96 = Non-covered charges.
- 97 = Payment is included in allowance for another service/procedure.
- 98 = The hospital must file the Medicare claim for this inpatient non-physician service.
INACTIVE
- 99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
- 100 = Payment made to patient/insured/responsible party.
- 101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
- 102 = Major medical adjustment.
- 103 = Provider promotional discount (i.e. Senior citizen

discount).

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/ service was not paid or identified on the claim.

108 = Claim/service reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/PROduct not approved by the Food and Drug Administration.

115 = Claim/service adjusted as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 =Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 =Patient is covered by a managed care plan. INACTIVE

121 =Indemnification adjustment.

122 =Psychiatric reduction.

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount - not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s).

126 =Deductible - Major Medical.

127 =Coinsurance - Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied - prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed or time limits not met.

139 = Contracted funding agreement - subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

- A2 = Contractual adjustment.
- A3 = Medicare Secondary Payer liability met. INACTIVE
- A4 = Medicare Claim PPS Capital Day Outlier Amount.
- A5 = Medicare Claim PPS Capital Cost Outlier Amount.
- A6 = Prior hospitalization or 30 day transfer requirement not met.
- A7 = Presumptive Payment Adjustment.
- A8 = Claim denied; ungroupable DRG.
- B1 = Non-covered visits.
- B2 = Covered visits. INACTIVE
- B3 = Covered charges. INACTIVE
- B4 = Late filing penalty.
- B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
- B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.
- B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
- B9 = Services not covered because the patient is enrolled in a Hospice.
- B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
- B11 = The claim/service has been transferred to the proper payer/ processor for processing. Claim/service not covered by this payer/processor.
- B12 = Services not documented in patients' medical records.
- B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

COMMENT: -

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REVANSI4

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). NOTE: This 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 OPSS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward. Valid beginning with NCH weekly process date 7/7/00.

SHORT NAME: REVANSI4

LONG NAME: REV_CNTR_4TH_ANSI_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES:

*****EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*****
*****POSITIONS 1 & 2 OF ANSI CODE*****

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

*****Claim Adjustment Reason Codes*****

*****POSITIONS 3 through 5 of ANSI CODE*****

- 1 = Deductible Amount
- 2 = Coinsurance Amount
- 3 = Co-pay Amount
- 4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 5 = The procedure code/bill type is inconsistent with the place of service.
- 6 = The procedure code is inconsistent with the patient's age.
- 7 = The procedure code is inconsistent with the patient's gender.
- 8 = The procedure code is inconsistent with the provider type.
- 9 = The diagnosis is inconsistent with the patient's age.
- 10 = The diagnosis is inconsistent with the patient's gender.
- 11 = The diagnosis is inconsistent with the procedure.
- 12 = The diagnosis is inconsistent with the provider type.
- 13 = The date of death precedes the date of service.
- 14 = The date of birth follows the date of service.
- 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 16 = Claim/service lacks information which is needed for adjudication.
- 17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
- 18 = Duplicate claim/service.
- 19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
- 20 = Claim denied because this injury/illness is covered by the liability carrier.
- 21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
- 22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

- 23 = Claim adjusted because charges have been paid by another payer.
- 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 25 = Payment denied. Your Stop loss deductible has not been met.
- 26 = Expenses incurred prior to coverage.
- 27 = Expenses incurred after coverage terminated.
- 28 = Coverage not in effect at the time the service was provided.
- 29 = The time limit for filing has expired.
- 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
- 31 = Claim denied as patient cannot be identified as our insured.
- 32 = Our records indicate that this dependent is not an eligible dependent as defined.
- 33 = Claim denied. Insured has no dependent coverage.
- 34 = Claim denied. Insured has no coverage for newborns.
- 35 = Benefit maximum has been reached.
- 36 = Balance does not exceed copayment amount.
- 37 = Balance does not exceed deductible amount.
- 38 = Services not provided or authorized by designated (network) providers.
- 39 = Services denied at the time authorization/pre-certification was requested.
- 40 =Charges do not meet qualifications for emergency/urgent care.
- 41 =Discount agreed to in Preferred Provider contract.
- 42 =Charges exceed our fee schedule or maximum allowable amount.
- 43 =Gramm-Rudman reduction.
- 44 =Prompt-pay discount.
- 45 =Charges exceed your contracted/legislated fee arrangement.
- 46 =This (these) service(s) is (are) not covered.

- 47 = This (these) diagnosis (es) is (are) not covered, missing, or are invalid.
- 48 = This (these) procedure(s) is(are) not covered.
- 49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 51 = These are non-covered services because this a pre-existing condition.
- 52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
- 53 = Services by an immediate relative or a member of the same household are not covered.
- 54 = Multiple physicians/assistants are not covered in this case.
- 55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
- 56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
- 57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
- 58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- 59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 60 = Charges for outpatient services with the proximity to inpatient services are not covered.
- 61 = Charges adjusted as penalty for failure to obtain second surgical opinion.
- 62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.
- 63 = Correction to a prior claim. INACTIVE
- 64 = Denial reversed per Medical Review. INACTIVE
- 65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
- 66 = Blood Deductible.
- 67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts.

88 = Adjustment amount represents collection against receivable created in prior overpayment.

89 = Professional fees removed from charges.

90 = Ingredient cost adjustment.

91 = Dispensing fee adjustment.

92 = Claim paid in full. INACTIVE

93 = No claim level adjustment. INACTIVE

- 94 = Process in excess of charges.
- 95 = Benefits adjusted. Plan procedures not followed.
- 96 = Non-covered charges.
- 97 = Payment is included in allowance for another service/procedure.
- 98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE
- 99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
- 100 = Payment made to patient/insured/responsible party.
- 101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
- 102 = Major medical adjustment.
- 103 = Provider promotional discount (i.e. Senior citizen discount).
- 104 = Managed care withholding.
- 105 = Tax withholding.
- 106 = Patient payment option/election not in effect.
- 107 = Claim/service denied because the related or qualifying claim/ service was not paid or identified on the claim.
- 108 = Claim/service reduced because rent/purchase guidelines were not met.
- 109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 110 = Billing date predates service date.
- 111 = Not covered unless the provider accepts assignment.
- 112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.
- 113 = Claim denied because service/procedure was provided outside the United States or as a result of war.
- 114 = Procedure/Product not approved by the Food and Drug Administration.
- 115 = Claim/service adjusted as procedure postponed or canceled.
- 116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 =Charges reduced for ESRD network support.

119 =Benefit maximum for this time period has been reached.

120 =Patient is covered by a managed care plan. INACTIVE

121 =Indemnification adjustment.

122 =Psychiatric reduction.

123 =Payer refund due to overpayment. INACTIVE

124 =Payer refund amount - not our patient. INACTIVE

125 =Claim/service adjusted due to a submission/billing error(s).

126 =Deductible - Major Medical.

127 = Coinsurance - Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied - prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 =Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed or time limits not met.

139 = Contracted funding agreement - subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount.

A6 = Prior hospitalization or 30 day transfer requirement not met.

A7 = Presumptive Payment Adjustment.

A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/ processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

COMMENT: -

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REVBLOOD

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: CWF

VALUES: -

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.

NOTE: This 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.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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REVDCTBL

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: CWF

VALUES: -

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.

NOTE: This 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.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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REVDEDCD

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: CWF

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

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REVPMT

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: CWF

VALUES: -

COMMENT: NOTE1: This 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. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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REVSTIND

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: CWF

VALUES: A = Services not paid under OPSS; uses a different fee schedule (e.g., ambulance, PT, mammography)

B = Non-allowed item or service for OPSS; may be paid under a different bill type (e.g., CORF)

C = Inpatient procedure (not paid under OPSS)

E = Non-allowed item or service (not paid by OPSS or any other Medicare payment system)

F = Corneal tissue acquisition and certain CRNA services and Hepatitis B vaccinations

G = Drug/biological pass-through (separate APC includes this pass-through amount)

H = Device pass-through (separate cost-based pass-through payment, not subject to coinsurance)

J = New drug or new biological pass-through

J1= Primary service and all adjunctive services on the claim (comprehensive APC; effective 01/2015)

- K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources (paid under OPPS; separate APC payment)

- L = Flu/PPV vaccines

- M = Service not billable to fiscal intermediary [now a MAC] (not paid under OPPS)

- N = Packaged incidental service no separate APC payment)

- P = Paid partial hospitalization per diem APC payment

- Q1 = Separate payment made; OPPS - APC (effective 2009)

- Q2 = No separate payment made; OPPS - APC were packaged into payment for other services (effective 2009)

- Q3 = May be paid through a composite APC-based on composite-specific criteria or separately through single code APCs when the criteria are not met (effective 2009)

- R = Blood products

- S = Significant procedure not subject to multiple procedure discounting

- T = Significant procedure subject to multiple procedure discounting

- U = Brachytherapy

- V = Medical visit to clinic or emergency department

- W = Invalid HCPCS or invalid revenue code with blank HCPCS

- X = Ancillary service

- Y = Non-implantable DME, (e.g., therapeutic shoes; not paid under OPPS -bill to DMERC)

- Z = Valid revenue with blank HCPCS and no other SI assigned

COMMENT:

This 2-byte indicator was added 10/2005 due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded

payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

NOTE: This 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.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

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RIC_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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RLT_COND

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: CWF

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

=====

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

02 = Employment related - Patient alleged that the medical condition causing this

episode of care was due to environment/events resulting from employment.

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

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

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

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

07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.

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

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

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

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

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

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

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

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

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

17 = Patient is homeless.

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

- 19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.
- 20 = Beneficiary requested billing – Provider realizes the services on this bill are at a non-covered level of care or otherwise excluded from coverage, but the bene has requested formal determination
- 21 = Billing for denial notice - The SNF or HHA realizes services are at a non-covered level of care or excluded, but requests a Medicare denial in order to bill Medicaid or other insurer
- 22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy
- 23 = Homecare-giver 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. (Effective 10/01)
- 43 = Continuing Care Not Provided Within Prescribed Post-discharge Window - continuing care was related to the inpatient admission but the prescribed care was not provided within the post-discharge window.(eff. 10/01)
- 44 = Inpatient Admission Changed to Outpatient - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. (Effective 4/1/04)
- 45 = Reserved for national assignment.
- 46 = Non-availability statement on file for TRICARE claim for nonemergency IP care for TRICARE bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
- 47 = Reserved for TRICARE.
- 48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs). Claims submitted by TRICARE.
- 49 = Product Replacement within Product Lifecycle- replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)
- 50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement. (Effective 4/2006)
- 51 = Reserved for national assignment.

- 52 = Reserved for national assignment.
- 53 = Reserved for national assignment.
- 54 = Reserved for national assignment.
- 55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
- 56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
- 57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
- 58 = Terminated Managed Care Organization Enrollee - patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.
- 59 = Non-primary ESRD Facility - ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. (Effective 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 a patient in State or local custody meets the requirements of 42 CFR 411.4(b) for payment
- 64 = Other than clean claim - The claim is not a 'clean claim'
- 65 = Non-PPS bill - The bill is not a prospective payment system bill.
- 66 = Hospital Does Not Wish Cost Outlier Payment - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)
- 67 = Beneficiary elects not to use Lifetime Reserve (LTR) days 68 = Beneficiary elects to use LTR days
- 69 = IME / DGME / N&AH Payment Only - providers request for a supplemental payment for IME / DGME / N&AH (Indirect Medical Education/Graduate Medical Education/ Nursing and Allied Health).
- 70 = Self-administered Epoetin (EPO) - Billing is for a home dialysis patient who self-administers EPO.

- 71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
- 72 = Self-care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
- 73 = Self-care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
- 74 = Home - Billing is for a patient who received dialysis services at home.
- 75 = Home dialysis patient using a dialysis machine that was purchased under the 100% program.
- 76 = Back-up in facility dialysis - Billing is for a patient who received dialysis services in a back-up facility.
- 77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by the primary payer as payment in full - no Medicare payment is due.
- 78 = New coverage not implemented by HMO, indicates newly covered service under Medicare for which HMO does not pay.
- 79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.
- 80 = Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. (Effective 4/4/05)
- 81-99 = Reserved for state assignment.
- A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (Effective 9/01)
- A1 = EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code.
- A2 = Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped.
- A3 = Special federal funding - Designed for uniform use by state uniform billing committees. Special program indicator code
- A4 = Family planning - Designed for uniform use by state uniform billing committees. Special program indicator code
- A5 = Disability - Designed for uniform use by state uniform billing committees.

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

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

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

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

AA = Abortion Performed due to Rape (eff. 10/1/02)

AB = Abortion Performed due to Incest (eff. 10/1/02)

AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality
(eff. 10/1/02)

AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising
from or exacerbated by the Pregnancy itself (eff. 10/1/02)

AE = Abortion Performed due to physical health of mother that is not life endangering
(eff. 10/1/02)

AF = Abortion Performed due to emotional/psychological health of mother (eff.
10/1/02)

AG = Abortion performed due to social economic reasons (eff. 10/1/02)

AH = Elective Abortion (eff. 10/1/02)

AI = Sterilization (eff. 10/1/02)

AJ = Payer Responsible for copayment (4/1/03)

AK = Air Ambulance Required - For ambulance claims.
Time needed to transport poses a threat. (Effective 10/16/03)

AL = Specialized Treatment/bed Unavailable - For ambulance claims. Specialized
treatment bed unavailable. Transported to alternate facility. (Effective 10/16/03)

AM = Non-emergency Medically Necessary Stretcher Transport Required - For
ambulance claims. Non-emergency medically necessary stretcher transport
required. (Effective 10/16/03)

AN = Preadmission Screening Not Required - person meets the criteria for an exemption
from preadmission screening. (Effective 1/1/04)

BO = Medicare Coordinated Care Demonstration Program patient is a participant in a

Medicare Coordinated Care Demonstration (eff. 10/01)

- B1 = Beneficiary ineligible for demonstration program (eff. 1/02).
- B2 = Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule
- B3 = Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law. (Effective 10/16/03)
- B4 = Admission Unrelated to Discharge - Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.
- B5 = Special program indicator Reserved for national assignment.
- B6 = Special program indicator Reserved for national assignment.
- B7 = Special program indicator Reserved for national assignment.
- B8 = Special program indicator Reserved for national assignment.
- B9 = Special program indicator Reserved for national assignment.
- C0 = Reserved for national assignment.
- C1 = Approved as billed - Claim has been reviewed by the QIO and has been fully approved including any outlier.
- C2 = QIO approval indicator services NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C3 = Partial approval - some portion (days or services). From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code "77" in FL 36 or code "46" in FL 39-41).
- C4 = Admission denied - The patient's need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary.
- C5 = Post-payment review applicable - Any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
- C6 = Preadmission/Pre-procedure authorization - The QIO authorized this admission/procedure but has not reviewed the services provided.
- C7 = Extended authorization - The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
- C8 = Reserved for national assignment. QIO approval indicator services

- C9 = Reserved for national assignment. QIO approval indicator services
- D0 = Changes to service dates.
- D1 = Changes in charges.
- D2 = Changes in revenue codes/HCPCS/HIPPS Rate Code - Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/ HCPCS/HIPPS Rate Codes (FL44)
- D3 = Second or subsequent interim PPS bill.
- D4 = Change in ICD-9-CM diagnosis and/or procedure code
- D5 = Cancel only to correct a beneficiary claim account number (HICN) or provider identification number.
- D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill).
- D7 = Change to make Medicare the secondary payer.
- D8 = Change to make Medicare the primary payer.
- D9 = Any other change.
- DR = Disaster Relief (eff. 10/2005) - Code used to facilitate claims processing and track services and items provided to victims of Hurricane Katrina and any future disasters.
- E0 = Change in patient status.
- EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study
- G0 = Distinct Medical Visit - Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits.
- H0 = Delayed Filing, Statement of Intent Submitted - statement of intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
- M0 = All-inclusive rate for outpatient services. Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.
- M1 = Roster billed influenza virus vaccine or pneumococcal pneumonia vaccine (PPV).

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

MA - GI Bleed.

MB - Pneumonia.

MC - Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

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

XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/07)

COMMENT: -

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RLTCNDSQ

LABEL: Claim Related Condition Code Sequence

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

SHORT NAME: RLTCNDSQ

LONG NAME: RLT_COND_CD_SEQ

TYPE: CHAR

LENGTH: 3

SOURCE: CCW

VALUES: -

COMMENT: -

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RLTOCRSQ

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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RLTSPNSQ

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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RLTVALSQ

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: Revenue Center Rendering Physician NPI

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

VALUES: -

COMMENT: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy numbers) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

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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: -

VALES: -

COMMENT: -

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RPRVDPMT

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: CWF

VALUES: -

COMMENT: This 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 OPSS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE: Additional information regarding claim versus revenue-line level payments can be found in a CCW Technical Guidance document entitled: "Getting Started with Medicare data."

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RSN_VISIT_CD1

LABEL: Reason for Visit Diagnosis Code I

DESCRIPTION: The diagnosis code used to identify the patient's reason for the Hospital Outpatient visit.

SHORT NAME: RSN_VISIT_CD1

LONG NAME: RSN_VISIT_CD1

TYPE: CHAR

LENGTH: 7

SOURCE: -

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.

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RSN_VISIT_CD2

LABEL: Reason for Visit Diagnosis Code II

DESCRIPTION: The diagnosis code used to identify the patient's reason for the Hospital Outpatient visit.

SHORT NAME: RSN_VISIT_CD2

LONG NAME: RSN_VISIT_CD2

TYPE: CHAR

LENGTH: 7

SOURCE: -

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.

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RSN_VISIT_CD3

LABEL: Reason for Visit Diagnosis Code III

DESCRIPTION: The diagnosis code used to identify the patient's reason for the Hospital Outpatient visit.

SHORT NAME: RSN_VISIT_CD3

LONG NAME: RSN_VISIT_CD3

TYPE: CHAR

LENGTH: 7

SOURCE: -

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.

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RSN_VISIT_VRSN_CD1

LABEL: Reason for Visit Diagnosis Code I Diagnosis Version Code (ICD-9 or ICD-10)

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

SHORT NAME: RSN_VISIT_VRSN_CD1

LONG NAME: RSN_VISIT_VRSN_CD1

TYPE: CHAR

LENGTH: 1

SOURCE: -

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. ICD-10 is not scheduled for implementation until 10/2015.

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RSN_VISIT_VRSN_CD2

LABEL: Reason for Visit Diagnosis Code II Diagnosis Version Code (ICD-9 or ICD-10)

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

SHORT NAME: RSN_VISIT_VRSN_CD2

LONG NAME: RSN_VISIT_VRSN_CD2

TYPE: CHAR

LENGTH: 1

SOURCE: -

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. ICD-10 is not scheduled for implementation until 10/2015.

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RSN_VISIT_VRSN_CD3

LABEL: Reason for Visit Diagnosis Code III Diagnosis Version Code (ICD-9 or ICD-10)

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

SHORT NAME: RSN_VISIT_VRSN_CD3

LONG NAME: RSN_VISIT_VRSN_CD3

TYPE: CHAR

LENGTH: 1

SOURCE: -

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. ICD-10 is not scheduled for implementation until 10/2015.

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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:	CWF
VALUES:	<p>70= Payer use only, the nonutilization 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</p> <p>71 = Hospital prior stay dates - the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.</p> <p>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.</p> <p>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.</p> <p>74 = Non-covered level of care - The from/thru dates of a period at a noncovered level of care in an otherwise covered stay, excluding any period reported with occurrence span code 76, 77, or 79.</p> <p>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.</p> <p>76 = Patient liability - From/thru dates of period of noncovered 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 noncovered period</p> <p>77 = Provider liability (utilization charged) - The from/thru dates of period of noncovered care for which the provider is liable. Applies to provider liability where bene is charged with utilization and is liable for deductible/ coinsurance</p> <p>78 = SNF prior stay dates - The from/thru dates of any SNF stay that ended within 60 days of this hospital or SNF admission.</p>

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. Noncovered 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 noncovered care that is denied due to lack of medical necessity or custodial care for which the provider is liable. (eff. 10/01)

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

COMMENT: -

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SPANFROM

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: CWF

VALUES: -

COMMENT: -

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SPANTHRU

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: CWF

VALUES: -

COMMENT: -

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SRC_ADMS

NAME: 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: CWF

CODE VALUES: For Inpatient/SNF Claims:

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

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

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

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

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

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

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

7 = Emergency room - The patient was admitted to this facility after receiving services in

this facility's emergency room department (CMS discontinued this code 07/2010, although a small number of claims with this code appear after that time).

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

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

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

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

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

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

E = Transfer from Ambulatory Surgical Center

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

1 = Normal delivery - A baby delivered without complications.

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

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

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

5 = Reserved for national assignment.

6 = Reserved for national assignment.

7 = Reserved for national assignment.

8 = Reserved for national assignment.

9 = Information not available.

COMMENT: -

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STATE_CD

LABEL: Beneficiary Residence (SSA) State Code

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

SHORT NAME: STATE_CD

LONG NAME: BENE_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: SSA/EDB

VALUES:

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

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

98 = Guam

99 = With 000 county code is American Samoa; otherwise unknown

COMMENT:

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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: CWF

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

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

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

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

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

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

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

07 = Left against medical advice or discontinued care.

08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)

- 09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
- 20 = Expired (patient did not recover).
- 21 = Discharged/transferred to court/law enforcement
- 30 = Still patient.
- 40 = Expired at home (hospice claims only)
- 41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
- 42 = Expired - place unknown (Hospice claims only)
- 43 = Discharged/transferred to a federal hospital (eff. 10/1/03)
- 50 = Discharged/transferred to a Hospice – home.
- 51 = Discharged/transferred to a Hospice – medical facility.
- 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
- 62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
- 63 = Discharged/transferred to a long term care hospitals. (eff. 1/2002)
- 64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002)
- 65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/ discharge status code '05' and given their own code). (eff. 1/2005).
- 66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
- 69 = Discharged/transferred to a designated disaster alternative care site (starting 10/2013; applies only to particular MS-DRGs*)

- 70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.
- 71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
- 72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05). The following codes apply only to particular MS-DRGs*, and were new in 10/2013:
- 81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission.
- 82 = Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission.
- 83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission.
- 84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.
- 85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission.
- 86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.
- 87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.
- 88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission.
- 89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.
- 90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.
- 91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.
- 92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.
- 93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.

94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.

95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

COMMENT: * MS-DRG codes where additional codes were available in October 2013 are: 280 (Acute Myocardial Infarction, Discharged Alive with MCC),
281 (Acute Myocardial Infarction, Discharged Alive with CC),
282 (Acute Myocardial Infarction, Discharged Alive without CC/MCC) and
789 (Neonates, Died or Transferred to Another Acute Care Facility).

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TDEDAMT

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: -

COMMENT: DERIVATION RULES: Accumulate the value amounts (CLM_VAL_AMT) associated with value codes (CLM_VAL_CD) equal to 06, 08 thru 11 and A1, B1 or C1 and move to IP_TOT_DDCTN_AMT.

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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: CWF

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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TOT_CHRG

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: CWF

VALUES: -

COMMENT: -

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TYPE_ADM

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: CWF

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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TYPESRVC

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: CWF

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, may be 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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UTIL_DAY

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: -

VALUES: -

COMMENT: -

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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: CWF

VALUES: -

COMMENT: -

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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: CWF

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

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

03 = Reserved for national assignment.

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

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

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

07 = Medicare cash deductible reserved for national assignment.

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

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

- 10 = Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
- 11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years
- 12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
- 13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
- 15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 16 = That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
- 17 = Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry).
- 18 = Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry).
- 19 = Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry).
- 20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

- 21 = Catastrophic - Medicaid - Eligibility requirements to be determined at state level.
- 22 = Surplus - Medicaid - Eligibility requirements to be determined at state level.
- 23 = Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level.
- 24 = Medicaid rate code - Medicaid – Eligibility requirements to be determined at state level.
- 25 = Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).
- 26 = Prescription Drugs Offset to Patient (Payment Amount Hearing and Ear Services) Hearing and ear services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement covers period).
- 27 = Offset to the Patient (Payment Amount - Vision and Eye Services) - Vision and eye services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 28 = Offset to the Patient (Payment Amount - Dental Services) - Dental services paid for out of a long term care facility resident/ patient's funds in the billing period submitted (Statement Covers Period).
- 29 = Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropractic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 31 = Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.
- 32 = Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination. (eff. 4/1/2003)
- 33 = Offset to the Patient Payment Amount (Podiatric Services) --

Podiatric services paid out of a long-term care facility resident/
patient's funds in the billing period submitted.

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

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

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

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

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

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

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

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

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

44 = Amount provider agreed to accept from primary payer when

amount less than charges but more than payment received -
When a lesser amount is received and the received amount is
less than charges, a Medicare secondary payment is due.

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

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

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

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

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

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

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

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

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

54 = New birth weight in grams - Actual birth weight or weight
at time of admission for an extramural birth. Required on

all claims with type of admission of '4' and on other claims as required by law.

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

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

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

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

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

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

61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.

NOTE: HHA claims with a thru date on or before 12/31/05, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/05, the value code amount field reflects the CBSA code.

62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

64 = Amount of home health payments attributed to the Part A trust

fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

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

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

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

69 = Reserved for national assignment

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

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

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

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

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

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

76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)

77 = New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case

(including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary. (eff. 4/1/03, under Inpatient PPS)

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

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

80-99 = Reserved for state assignment.

A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)

A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (eff. 10/93) - Prior value 07

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

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

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

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

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

A7 = Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount

involving the indicated payer.

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

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

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

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

B1 = Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07

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

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

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

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

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

C1 = Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07

- C2 = Coinsurance Payer C - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer.
- C3 = Estimated Responsibility Payer C - The stop/
- C7 = Copayment C -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
- CB = Other Assessments or Allowances (Payer C) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).
- D3 = Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.
- D4 = Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 10/1/07)
- G8 = Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08)
- XX = Total Charge Amount for all Part A visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part A visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
- XY = Total Charge Amount for all Part B visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part B visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
- XZ = Total Charge Amount for all Part B nonvisit charges on the

RIC 'U' claims - for Home Health claims containing both Part A & Part B services, this code identifies the total charge amount for the Part B non-visit charges. Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).

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

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

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

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

COMMENT: -

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VISITCNT

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: CWF

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'.

NOTE2: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.

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WAGEADJ

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: CWF

VALUES: -

COMMENT: Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see the list of MLN [publications at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html)).

NOTE1: This 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 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.

NOTE2: 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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WKLY_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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ZIP_CD

LABEL: ZIP Code of Residence from Claim

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

SHORT NAME: ZIP_CD

LONG NAME: BENE_MLG_CNTCT_ZIP_CD

TYPE: CHAR

LENGTH: 9

SOURCE: EDB

VALUES: -

COMMENT: -

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