Chronic Condition Data Warehouse

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Medicare Part B Non-Institutional File Codebook

May 2017

Version 1.0

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Revision History

Revision Date	Version Number	Description	Author(s)
05/15/2017	1.0	Initial release of Codebook for the Medicare Part B Non-Institutional File.	Kathy Schneider, Chris Alleman

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ALOWCHRG

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

DESCRIPTION: The total allowed charges on the claim (the sum of line item allowed charges).

SHORT NAME: ALOWCHRG

LONG NAME: NCH_CARR_CLM_ALOWD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: -

COMMENT: Sum of all the line LINE_NCH_PMT_AMT values for the claim.

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

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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ASGMNTCD

LABEL: Carrier Claim Provider Assignment Indicator Switch

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

SHORT NAME: ASGMNTCD

LONG NAME: CARR_CLM_PRVDR_ASGMNT_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

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

COMMENT: -

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ASTNT_CD

LABEL: Carrier Line Reduced Payment Physician Assistant Code

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

SHORT NAME: ASTNT_CD

LONG NAME: CARR_LINE_RDCD_PMT_PHYS_ASTN_C

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES: BLANK = Adjustment situation (where CLM_DISP_CD equal 3)

0 = N/A

1 = 65% of payment. Either physician assistants assisting in surgery or nurse midwives

2 = 75% of payment. Either physician assistants performing services in a hospital (other than assisting surgery) or nurse practitioners/clinical nurse specialist performing services in rural areas or clinical social worker services

3 = 85% of payment. Either physician assistant services for other than assisting surgery or other hospital services or nurse practitioners services (not in rural areas)

COMMENT: -

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BENE_ID

LABEL: Encrypted CCW Beneficiary ID

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

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

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

SHORT NAME: BENE_ID

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: -

CCW VALUES: -

COMMENT: -

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BENE_PMT

LABEL: NCH Claim Payment Amount to Beneficiary

DESCRIPTION: The total payments made to the beneficiary for this claim (sum of all line-level payments to beneficiary, variable called LINE_BENE_PMT_AMT)

SHORT NAME: BENE_PMT

LONG NAME: NCH_CLM_BENE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: -

COMMENT: This variable is populated if, for example, a beneficiary pays for a service that should have been Medicare-covered. The beneficiary can be refunded the payment.

Costs to that beneficiaries are liable for are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles and coinsurance amounts.

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

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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BETOS

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

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

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

SHORT NAME: BETOS

LONG NAME: BETOS_CD

TYPE: CHAR

LENGTH: 3

SOURCE: NCH

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

P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment of retinal lesions
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services (medicare fee schedule)
P9B = Dialysis services (non-medicare fee schedule)
I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck
I2B = Advanced imaging - CAT/CT/CTA: other
I2C = Advanced imaging - MRI/MRA: brain/head/neck
I2D = Advanced imaging - MRI/MRA: other
I3A = Echography/ultrasonography - eye
I3B = Echography/ultrasonography - abdomen/pelvis
I3C = Echography/ultrasonography - heart
I3D = Echography/ultrasonography - carotid arteries
I3E = Echography/ultrasonography - prostate, transrectal
I3F = Echography/ultrasonography - other
I4A = Imaging/procedure - heart including cardiac catheterization
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare fee schedule)
T1B = Lab tests - automated general profiles

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

COMMENT: -

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CARR_LINE_ANSTHSA_UNIT_CNT

LABEL: Carrier Line Anesthesia Unit Count

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

SHORT NAME: CARR_LINE_ANSTHSA_UNIT_CNT

LONG NAME: CARR_LINE_ANSTHSA_UNIT_CNT

TYPE: NUM

LENGTH: 2

SOURCE: CWF

VALUES: -

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

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CARR_LINE_CLIA_LAB_NUM

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

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

SHORT NAME: CARR_LINE_CLIA_LAB_NUM

LONG NAME: CARR_LINE_CLIA_LAB_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: CWF

VALUES: -

COMMENT: -

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CARR_NUM

LABEL: Carrier or MAC Number

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

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

SHORT NAME: CARR_NUM

LONG NAME: CARR_NUM

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES:
00510 = Alabama - CAHABA
00511 = Georgia - CAHABA
00512 = Mississippi - CAHABA (eff. 2000)
00520 = Arkansas BC/BS
00521 = New Mexico - Arkansas BC/BS (term. 2008) (replaced by MAC #04202)
00522 = Oklahoma - Arkansas BC/BS (term. 2008) (replaced by MAC #04302)
00523 = Missouri East - Arkansas BC/BS (term. 2008) (replaced by MAC #05392)
00524 = Rhode Island - Arkansas BC/BS (eff. 2004)
00528 = Louisiana - Arkansas BS
00590 = Florida - First Coast
00591 = Connecticut - First Coast (eff. 2000)
00630 = Indiana - Administar
00635 = DMERC-B - Administar (replaced by MAC #17003)
00640 = Iowa - Wellmark, Inc.
00645 = Nebraska - Iowa BS
00650 = Kansas BCBS (term. 2008) (replaced by MAC #05202)
00655 = Nebraska - Kansas BC/BS (term. 2008) (replaced by MAC #05402)
00660 = Kentucky - Administar
00740 = Western Missouri - Kansas BS (term.2008) (replaced by MAC #05302)
00751 = Montana BC/BS (replaced by MAC # 03202)
00801 = New York - Healthnow
00803 = New York - Empire BS
00805 = New Jersey - Empire BS
00811 = DMERC (A) - Healthnow (eff. 2000) (replaced by MAC #16003)
00820 = North Dakota - Noridian (replaced by MAC #03302)
00823 = Utah - Noridian (eff. 12/1/2005) (replaced by MAC #03502)
00824 = Colorado - Noridian (term. 2008) (replaced by MAC #04102)
00825 = Wyoming - Noridian (replaced by MAC #03602)

00826 = Iowa - Noridian (term. 2008) (replaced by MAC #05102)
00831 = Alaska - Noridian
00832 = Arizona - Noridian (replaced by MAC # 03102)
00833 = Hawaii - Noridian
00834 = Nevada - Noridian
00835 = Oregon - Noridian
00836 = Washington - Noridian
00865 = Pennsylvania - Highmark
00870 = Rhode Island BS (term. 2004)
00880 = South Carolina - Palmetto
00882 = RRB - South Carolina PGBA (eff. 2000)
00883 = Ohio - Palmetto (eff. 2002)
00884 = West Virginia - Palmetto (eff. 2002)
00885 = DMERC C - Palmetto (replaced by MAC #18003)
00889 = South Dakota - Noridian (eff. 4/1/2006) (replaced by MAC # 03402)
00900 = Texas - Trailblazer (term. 2008) (replaced by MAC # 04402)
00901 = Maryland - Trailblazer
00902 = Delaware - Trailblazer
00903 = District of Columbia - Trailblazer
00904 = Virginia - Trailblazer (eff. 2000)
00910 = Utah BS
00951 = Wisconsin - Wisconsin Phy Svc
00952 = Illinois - Wisconsin Phy Svc
00953 = Michigan - Wisconsin Phy Svc
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Puerto Rico - Triple S, Inc.
00974 = Triple-S, Inc. - Virgin Islands
02050 = California - TOLIC (term. 2000)
05130 = Idaho - CIGNA
05302 = Western Missouri (eff. 3/2008)
05440 = Tennessee - CIGNA
05535 = North Carolina - CIGNA
05655 = DMERC-D Alaska - CIGNA (replaced by MAC #19003)
10071 = Railroad Board Travelers (term. 2000)
10230 = Connecticut - Metra Health (term. 2000)
10240 = Minnesota - Metra Health (term. 2000)
10250 = Mississippi - Metra Health (term. 2000)
10490 = Virginia - Metra Health (term. 2000)
10555 = DMERC A - Travelers Insurance Co. (term. 2000)
14330 = New York - GHI
16360 = Ohio - Nationwide Insurance Co. (term. 2002)
16510 = West Virginia - Nationwide Insur Co.(term. 2002)
31140 = N. California - National Heritage Ins.
31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.
31146 = So. California - NHIC (eff. 2000)
80884 = Contractor ID for Physician Risk Adjustment Data (data not sent through CWF, but through Palmetto)

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Medicare Administrative Contractors (MACs)

JURISDICTION 3 -- Part B MACs

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

JURISDICTION 4 -- Part B MACs

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

JURISDICTION 5 -- Part B MACs

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

Durable Medical Equipment (DME) MACs

16003 = National Heritage Insur Co (NHIC) (eff. 7/1/06)
(replaces carrier #00811)

17003 = Administar Federal, Inc. (eff. 7/1/06)
(replaces carrier # 00635)

18003 = Palmetto GBA, LLC (eff. 6/1/07)
(replaces carrier #00885)

19003 = Noridan Administrative Services (eff. 10/1/06)
(replaces carrier #05655)

COMMENT: Prior to Version H this field was named: FICARR_IDENT_NUM.

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CARRXNUM

LABEL: Carrier Line RX Number

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

SHORT NAME: CARRXNUM

LONG NAME: CARR_LINE_RX_NUM

TYPE: CHAR

LENGTH: 30

SOURCE: CWF

VALUES: -

COMMENT: The prescription order number consists of:
--Vendor ID Number (positions 1 - 4)
--HCPCS Code (positions 5 - 9)
--Vendor Controlled Prescription Number (positions 10 - 30)

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

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CCLTRNUM

LABEL: Clinical Trial Number

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

SHORT NAME: CCLTRNUM

LONG NAME: CLM_CLNCL_TRIL_NUM

TYPE: CHAR

LENGTH: 8

SOURCE: -

VALUES: -

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

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

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CLM_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_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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COINAMT

LABEL: Line Beneficiary Coinsurance Amount

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

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

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

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

SHORT NAME: COINAMT

LONG NAME: LINE_COINSRNC_AMT

TYPE: NUM

LENGTH: 12

SOURCE: 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).

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DED_SW

LABEL: Line Service Deductible Indicator Switch

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

SHORT NAME: DED_SW

LONG NAME: LINE_SERVICE_DEDUCTIBLE

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES: 0 = SERVICE SUBJECT TO DEDUCTIBLE

1 = SERVICE NOT SUBJECT TO DEDUCTIBLE

COMMENT: -

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DEDAPPLY

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

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

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

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

SHORT NAME: DEDAPPLY

LONG NAME: CARR_CLM_CASH_DDCTBL_APLD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: 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.

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DISP_CD

LABEL: Claim Disposition Code

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

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

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

SHORT NAME: DISP_CD

LONG NAME: CLM_DISP_CD

TYPE: CHAR

LENGTH: 2

SOURCE: CWF

VALUES: 01 = Debit accepted

COMMENT: -

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DME_PURC

LABEL: Line DME Purchase Price Amount

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

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

SHORT NAME: DME_PURC

LONG NAME: LINE_DME_PRCHS_PRICE_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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DME_UNIT

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

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

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

SHORT NAME: DME_UNIT

LONG NAME: DMERC_LINE_MTUS_CNT

TYPE: NUM

LENGTH: 7

SOURCE: -

VALUES: -

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

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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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ENTRY_CD

LABEL: Carrier Claim Entry Code

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

SHORT NAME: ENTRY_CD

LONG NAME: CARR_CLM_ENTRY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

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

COMMENT: -

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EXPNSDT1

LABEL: Line First Expense Date

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

SHORT NAME: EXPNSDT1

LONG NAME: LINE_1ST_EXPNS_DT

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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EXPNSDT2

LABEL: Line Last Expense Date

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

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

SHORT NAME: EXPNSDT2

LONG NAME: LINE_LAST_EXPNS_DT

TYPE: DATE

LENGTH: 8

SOURCE: CWF

VALUES: -

COMMENT: -

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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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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 = U n k n o w n

1 = M a l e

2 = Female

COMMENT: -

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HCFASPCL

LABEL: Line CMS Provider Specialty Code

DESCRIPTION: CMS (previously called HCFA) specialty code used for pricing the line item service on the non-institutional claim.

Assigned by the Medicare Administrative Contractor (MAC) based on the corresponding provider identification number (performing NPI or UPIN).

SHORT NAME: HCFASPCL

LONG NAME: PRVDR_SPCLTY

TYPE: CHAR

LENGTH: 3

SOURCE: CWF

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

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

69 = Clinical laboratory (billing independently)
70 = Multispecialty clinic or group practice
71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
72 = Pain Management (eff. 1/1/02)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs -- eff. 4/1/03)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g. drug and department stores)
88 = Unknown supplier/provider specialty
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
95 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory
96 = Optician
97 = Physician assistant
98 = Gynecologist/oncologist
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = SNF (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home Health Agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)
B2 = Pedorthic Personnel (eff. 10/2/07)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/07)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ

procurement organizations,histocompatibility labs) (eff. 10/2/07)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology

COMMENT: -

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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).

^Back to TOC^

HCPCS_YR

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

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

SHORT NAME: HCPCS_YR

LONG NAME: CARR_CLM_HCPCS_YR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

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

COMMENT: -

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HCTHGBRS

LABEL: Hematocrit / Hemoglobin Test Results

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

SHORT NAME: HCTHGBRS

LONG NAME: LINE_HCT_HGB_RSLT_NUM

TYPE: NUM

LENGTH: 4

SOURCE: -

VALUES: -

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

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

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HCTHGBTP

LABEL: Hematocrit / Hemoglobin Test Type Code

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

SHORT NAME: HCTHGBTP

LONG NAME: LINE_HCT_HGB_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: -

VALUES:
R1 = Hemoglobin Test
R2 = Hematocrit Test

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

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

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HPSASCCD

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

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

SHORT NAME: HPSACCD

LONG NAME: HPSA_SCRCTY_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES:
1 = HPSA
2 = Scarcity
3 = Both
Space = Not applicable

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

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

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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).

^Back to TOC^

ICD_DGNS_CD3

LABEL: Claim Diagnosis Code III

DESCRIPTION: The diagnosis code in the 3rd position identifying the conditions(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 conditions(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 conditions(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 conditions(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 conditions(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 conditions(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 conditions(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 conditions(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_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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LALOWCHG

LABEL: Line Allowed Charge Amount

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

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

SHORT NAME: LALOWCHG

LONG NAME: LINE_ALOWD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

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

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LCLTY_CD

LABEL: Carrier Line Pricing Locality Code

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

SHORT NAME: LCLTY_CD

LONG NAME: CARR_LINE_PRCNG_LCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: CWF

VALUES: Medicare Localities

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

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

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

1 = ALABAMA
2 = ALASKA
3 = ARIZONA
4 = ARKANSAS
5 = ANAHEIM/SANTA ANA, CA
6 = LOS ANGELES, CA
7 = MARIN/NAPA/SOLANO, CA
8 = OAKLAND/BERKELEY, CA
9 = REST OF CALIFORNIA
10 = SAN FRANCISCO, CA
11 = SAN MATEO, CA
12 = SANTA CLARA, CA
13 = VENTURA, CA
14 = COLORADO
15 = CONNECTICUT

16 = DC + MD/VA SUBURBS
17 = DELAWARE
18 = FORT LAUDERDALE, FL
19 = MIAMI, FL
20 = REST OF FLORIDA
21 = ATLANTA, GA
22 = REST OF GEORGIA
23 = HAWAII
24 = IDAHO
25 = CHICAGO, IL
26 = EAST ST. LOUIS, IL
27 = REST OF ILLINOIS
28 = SUBURBAN CHICAGO, IL
29 = INDIANA
30 = IOWA
31 = KANSAS
32 = KENTUCKY
33 = NEW ORLEANS, LA
34 = REST OF LOUISIANA
35 = REST OF MAINE
36 = SOUTHERN MAINE
37 = BALTIMORE/SURR. CNTYS, MD
38 = REST OF MARYLAND
39 = METROPOLITAN BOSTON
40 = REST OF MASSACHUSETTS
41 = DETROIT, MI
42 = REST OF MICHIGAN
43 = MINNESOTA
44 = MISSISSIPPI
45 = METROPOLITAN KANSAS CITY, MO
46 = METROPOLITAN ST. LOUIS, MO
47 = REST OF MISSOURI
48 = MONTANA
49 = NEBRASKA
50 = NEVADA
51 = NEW HAMPSHIRE
52 = NORTHERN NJ
53 = REST OF NEW JERSEY
54 = NEW MEXICO
55 = MANHATTAN, NY

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

COMMENT: -

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LDEDAMT

LABEL: Line Beneficiary Part B Deductible Amount

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

SHORT NAME: LDEDAMT

LONG NAME: LINE_BENE_PTB_DDCTBL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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LINE_ICD_DGNS_CD

LABEL: Line Diagnosis Code

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

SHORT NAME: LINE_ICD_DGNS_CD

LONG NAME: LINE_ICD_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: CWF

VALUES: -

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

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LINE_ICD_DGNS_VRSN_CD

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

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

SHORT NAME: LINE_ICD_DGNS_VRSN_CD

LONG NAME: LINE_ICD_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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LINE_NUM

LABEL: Claim Line Number

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

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

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

SHORT NAME: LINE_NUM

LONG NAME: LINE_NUM

TYPE: NUM

LENGTH: 13

SOURCE: CCW

VALUES: -

COMMENT: -

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LINEPMT

LABEL: Line NCH Medicare Payment Amount

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

SHORT NAME: LINEPMT

LONG NAME: LINE_NCH_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: -

COMMENT: -

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LNNDCCD

LABEL: Line National Drug Code (NDC)

DESCRIPTION: On the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs.

This line item field was added as a placeholder on the Carrier claim.

SHORT NAME: LNNDCCD

LONG NAME: LINE_NDC_CD

TYPE: CHAR

LENGTH: 11

SOURCE: CWF

VALUES: -

COMMENT: -

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LPRPAYCD

LABEL: Line Primary Payer Code (if not Medicare)

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

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

SHORT NAME: LPRPAYCD

LONG NAME: LINE_BENE_PRMRY_PYR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF, VA, DOL, SSA

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

COMMENT: Values C, M, N and BLANK indicate Medicare is primary payer.

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LPRPDAMT

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

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

SHORT NAME: LPRPDAMT

LONG NAME: LINE_BENE_PRMRY_PYR_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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LPRVPMT

LABEL: Line Provider Payment Amount

DESCRIPTION: The payment made by Medicare to the provider for the line item service on the non-institutional claim. Additional payments may have been made to the provider - including beneficiary deductible and coinsurance amounts and/or other primary payer amounts.

SHORT NAME: LPRVPMT

LONG NAME: LINE_PRVDR_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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LSBMTCHG

LABEL: Line Submitted Charge Amount

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

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

SHORT NAME: LSBMTCHG

LONG NAME: LINE_SBMTD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

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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MDFR_CD3

LABEL: HCPCS Third Modifier Code

DESCRIPTION: A third modifier to the HCPCS procedure code to make it more specific than the first or second modifier codes to identify the line procedures for the claim.

SHORT NAME: MDFR_CD3

LONG NAME: HCPCS_3RD_MDFR_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES: -

COMMENT: Available for DME line items.

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MDFR_CD4

LABEL: HCPCS Fourth Modifier Code

DESCRIPTION: A fourth modifier to the HCPCS procedure code to make it more specific than the first, second or third modifier codes to identify the line item procedures for the claim.

SHORT NAME: MDFR_CD4

LONG NAME: HCPCS_4TH_MDFR_CD

TYPE: CHAR

LENGTH: 5

SOURCE: CWF

VALUES: -

COMMENT: Available for DME line items.

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MTUS_CNT

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

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

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

SHORT NAME: MTUS_CNT

LONG NAME: CARR_LINE_MTUS_CNT

TYPE: NUM

LENGTH: 5

SOURCE: CWF

VALUES: -

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

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MTUS_IND

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

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

SHORT NAME: MTUS_IND

LONG NAME: CARR_LINE_MTUS_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

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

COMMENT: -

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PLCSRVC

LABEL: Line Place of Service Code

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

SHORT NAME: PLCSRVC

LONG NAME: LINE_PLACE_OF_SRVC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: CWF

VALUES: 1 = Pharmacy. A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.

2 = Unassigned. N/A

3 = School. A facility whose primary purpose is education.

4 = Homeless Shelter. A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

5 = Indian Health Service - Free-standing Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.

6 = Indian Health Service - Provider-based Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.

7 = Tribal 638 - Free-standing Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

8 = Tribal 638 Provider-based Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-

surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

9 = Prison/Correctional Facility. A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.

10 = Unassigned. N/A

11 = Office. Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 = Home. Location, other than a hospital or other facility, where the patient receives care in a private residence.

13 = Assisted Living Facility. Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.

14 = Group Home. A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).

15 = Mobile Unit. A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

16 = Temporary Lodging. A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

17 = Walk-in Retail Health Clinic. A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

18 = Unassigned. N/A

19 = Unassigned. N/A

20 = Urgent Care Facility. Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 = Inpatient Hospital. A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 = Outpatient Hospital. A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 = Emergency Room – Hospital. A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 = Ambulatory Surgical Center. A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 = Birthing Center. A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

26 = Military Treatment Facility. A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27 = Unassigned. N/A

28 = Unassigned. N/A

29 = Unassigned. N/A

30 = Unassigned. N/A

31 = Skilled Nursing Facility. A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 = Nursing Facility. A facility which primarily provides skilled nursing care and related services to residents for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 = Custodial Care Facility. A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 = Hospice. A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

35-40 = Unassigned. N/A

41 = Ambulance - Land. A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 = Ambulance – Air or Water. An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

43-48 = Unassigned. N/A

49 = Independent Clinic. A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (Effective 10/1/03)

50 = Fed Qualified Health Ctr. A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 = Inpatient Psych Facility. A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 = Psychiatric Facility - Partial Hospitalization. A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 = Community Mental Health Ctr. A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

54 = Intermediate Care/Mentally Retarded Facility. A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 = Residential Substance Abuse Treatment Facility. A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 = Psychiatric Residential Treatment Center. A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57 = Non-residential Substance Abuse Treatment Facility. A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

58 = Unassigned. N/A

59 = Unassigned. N/A

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

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

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

63 = Unassigned. N/A

64 = Unassigned. N/A

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

66-70 = Unassigned. N/A

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

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

73-80 = Unassigned. N/A

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

82-98 = Unassigned. N/A

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

COMMENT: -

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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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PMTDNLCD

LABEL: Carrier Claim Payment Denial Code

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

SHORT NAME: PMTDNLCD

LONG NAME: CARR_CLM_PMT_DNL_CD

TYPE: CHAR

LENGTH: 2

SOURCE: -

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

0 = Denied

1 = Physician/supplier

2 = Beneficiary

3 = Both physician/supplier and beneficiary

4 = Hospital (hospital based physicians)

5 = Both hospital and beneficiary

6 = Group practice prepayment plan

7 = Other entries (e.g. Employer, union)

8 = Federally funded

9 = PA service

A = Beneficiary under limitation of liability

B = Physician/supplier under limitation of liability

D = Denied due to demonstration involvement

E = MSP cost avoided IRS/SSA/HCFA Data Match (after 01/2001 is First Claim Development)

F = MSP cost avoided HMO Rate Cell (after 1/2001 is Trauma Code Development)

G = MSP cost avoided Litigation Settlement (after 1/2001 is Secondary Claims Investigation)

H = MSP cost avoided Employer Voluntary Reporting (after 1/2001 is Self Reports)

J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)

K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)

P = Physician ownership denial

Q = MSP cost avoided - voluntary agreements including with employer

T = MSP cost avoided - Initial Enrollment Questionnaire

U = MSP cost avoided - HMO rate cell adjustment

V = MSP cost avoided - litigation settlement

X = MSP cost avoided - generic

Y = MSP cost avoided - IRS/SSA data match

00 = MSP cost avoided - COB Contractor

12 = MSP cost avoided - BC/BS Voluntary Data Sharing Agreements (VDSA)

13 = MSP cost avoided - Office of Personnel Management (OPM) Data Match

14 = MSP cost avoided - Workman's Compensation (WC) Data Match

15 = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA)

16 = MSP cost avoided - Liability Insurer VDSA

17 = MSP cost avoided - No-Fault Insurer VDSA

18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement

21 = MSP cost avoided - MIR Group Health Plan

22 = MSP cost avoided - MIR non-Group Health Plan

25 = MSP cost avoided - Recovery Audit Contractor - California

26 = MSP cost avoided - Recovery Audit Contractor - Florida

41 = MSP cost avoided - non-Group Health Plan non-Ongoing responsibility for medical (ORM)

43 = MSP cost avoided - Medicare Part C/Medicare Advantage

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

! = MSP cost avoided - COB Contractor (converted to '00' 2-byte code)

@ = MSP cost avoided - BC/BS Voluntary Agreements (converted to '12' 2-byte code)

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

$ = MSP cost avoided - Workman's Compensation (WC) Datamatch (converted to '14' 2-byte code)

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

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

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

+ = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006) (converted to '18' 2 -byte code)

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

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

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

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

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

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

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PMTINDSW

LABEL: Line Payment 80% / 100% Code

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

SHORT NAME: PMTINDSW

LONG NAME: LINE_PMT_80_100_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

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

COMMENT: -

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PRCNG_ST

LABEL: DMERC Line Pricing State Code (SSA)

DESCRIPTION: The 2-digit SSA state code where the DME supplier was located; used by the MAC for pricing the service.

SHORT NAME: PRCNG_ST

LONG NAME: DMERC_LINE_PRCNG_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: CWF/NCH

VALUES:
01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan

24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = California
56 = Canada & Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions

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

COMMENT: -

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PRCNGIND

LABEL: Line Processing Indicator Code

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

SHORT NAME: PRCNGIND

LONG NAME: LINE_PRCSG_IND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: CWF

VALUES:

A = Allowed

B = Benefits exhausted

C = Non-covered care

D = Denied (from BMAD)

I = Invalid data

L = CLIA

M = Multiple submittal--duplicate line item

N = Medically unnecessary

O = Other

P = Physician ownership denial

Q = MSP cost avoided (contractor #88888) - voluntary agreement

R = Reprocessed--adjustments based on subsequent reprocessing of claim

S = Secondary payer

T = MSP cost avoided - IEQ contractor

U = MSP cost avoided - HMO rate cell adjustment

V = MSP cost avoided - litigation settlement

X = MSP cost avoided - generic

Y = MSP cost avoided - IRS/SSA data match project

Z = Bundled test, no payment

00 = MSP cost avoided - COB Contractor

12 = MSP cost avoided - BC/BS Voluntary Agreements

13 = MSP cost avoided - Office of Personnel Management

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

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

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

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

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

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

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

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

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

Effective 4/1/02, the Line Processing Indicator code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code.

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

! MSP cost avoided - COB Contractor ('00' 2-byte code)

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

MSP cost avoided - Office of Personnel Management ('13' 2-byte code)

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

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

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

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

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

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

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

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

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

COMMENT: -

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PRF_PRFL

LABEL: Carrier Line Performing Provider ID Number (PIN)

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

SHORT NAME: PRF_PRFL

LONG NAME: CARR_PRFRNG_PIN_NUM

TYPE: CHAR

LENGTH: 15

SOURCE: CWF

VALUES: -

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

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PRF_UPIN

LABEL: Carrier Line Performing UPIN Number

DESCRIPTION: The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC).

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

SHORT NAME: PRF_UPIN

LONG NAME: PRF_PHYSN_UPIN

TYPE: CHAR

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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PRFNPI

LABEL: Carrier Line Performing NPI Number

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

SHORT NAME: PRFNPI

LONG NAME: PRF_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: CWF

VALUES: -

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

The UPIN is almost never populated after 2009.

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PRGRPNPI

LABEL: Carrier Line Performing Group NPI Number

DESCRIPTION: The National Provider Identifier (NPI) of the group practice, where the performing physician is part of that group.

SHORT NAME: PRGRPNPI

LONG NAME: ORG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: CWF

VALUES: -

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

(During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

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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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PROV_PMT

LABEL: NCH Claim Provider Payment Amount

DESCRIPTION: The total payments made to the provider for this claim (sum of line item provider payment amounts (variable called LINE_PRVDR_PMT_AMT).

SHORT NAME: PROV_PMT

LONG NAME: NCH_CLM_PRVDR_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: -

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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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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PROVZIP

LABEL: Carrier Line Performing Provider ZIP Code

DESCRIPTION: The ZIP code of the physician/supplier who performed the Part B service for this line item on the carrier claim (non-DMERC).

SHORT NAME: PROVZIP

LONG NAME: PRVDR_ZIP

TYPE: CHAR

LENGTH: 9

SOURCE: CWF

VALUES: -

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 and 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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PRPYALOW

LABEL: Line Primary Payer Allowed Charge Amount

DESCRIPTION: The primary payer allowed charge amount for the line item service on the non-institutional claim.

If there is a primary payer other than Medicare, there may be an allowed payment for the provider; if so, this field is populated.

SHORT NAME: PRPYALOW

LONG NAME: LINE_PRMRY_ALOWD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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PRTCPTG

LABEL: Line Provider Participating Indicator Code

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

SHORT NAME: PRTCPTG

LONG NAME: PRTCPTNG_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES:

1 = Participating

2 = All or some covered and allowed expenses applied to deductible Participating

3 = Assignment accepted/non-participating

4 = Assignment not accepted/non-participating

5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating.

6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating.

7 = Participating provider not accepting assignment

COMMENT: -

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PRV_TYPE

LABEL: Carrier Line Provider Type Code

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

SHORT NAME: PRV_TYPE

LONG NAME: CARR_LINE_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES: For Physician/Supplier Claims:

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

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

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

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

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

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

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

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

COMMENT: -

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PRVSTATE

LABEL: Line Provider State Code (SSA)

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

SHORT NAME: PRVSTATE

LONG NAME: PRVDR_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

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

32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = 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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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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RFR_NPI

LABEL: Carrier/DMERC Claim Referring Physician NPI Number

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

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

SHORT NAME: RFR_NPI

LONG NAME: RFR_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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RFR_PRFL

LABEL: Carrier Claim Referring Provider ID Number (PIN)

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

SHORT NAME: RFR_PRFL

LONG NAME: CARR_CLM_RFRNG_PIN_NUM

TYPE: CHAR

LENGTH: 14

SOURCE: CWF

VALUES: -

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

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RFR_UPIN

LABEL: Carrier/DMERC Claim Ordering Physician UPIN Number

DESCRIPTION: The unique physician identification number (UPIN) of the physician who referred the beneficiary or the physician who ordered the Part B services or durable medical equipment (DME).

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

SHORT NAME: RFR_UPIN

LONG NAME: RFR_PHYSN_UPIN

TYPE: CHAR

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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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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SBMTCHRG

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

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

SHORT NAME: SBMTCHRG

LONG NAME: NCH_CARR_CLM_SBMTD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH QA Process

VALUES: -

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

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

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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SCRNSVGS

LABEL: DMERC Line Screen Savings Amount

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

SHORT NAME: SCRNSVGS

LONG NAME: DMERC_LINE_SCRN_SVGS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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SRVC_CNT

LABEL: Line Service Count

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

SHORT NAME: SRVC_CNT

LONG NAME: LINE_SRVC_CNT

TYPE: NUM

LENGTH: 4

SOURCE: CWF

VALUES: -

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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SUP_NPI

LABEL: DMERC Line Item Supplier NPI Number

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

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

SHORT NAME: SUP_NPI

LONG NAME: PRVDR_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: CWF

VALUES: -

COMMENT: -

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SUP_TYPE

LABEL: DMERC Line Supplier Type Code

DESCRIPTION: The type of DMERC supplier.

SHORT NAME: SUP_TYPE

LONG NAME: DMERC_LINE_SUPPLR_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

VALUES:

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

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

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

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

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

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

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

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

8 = Other entities for whom employer identification (EI) numbers are used in coding

the ID field or proprietorship for whom EI numbers are used in coding the ID field.

COMMENT: -

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SUPLRNUM

LABEL: DMERC Line Supplier Provider Number

DESCRIPTION: The billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.

SHORT NAME: SUPLRNUM

LONG NAME: PRVDR_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: CWF

VALUES: -

COMMENT: Different types of identifiers may be used.
Refer to the variable called DMERC_LINE_SUPPLR_TYPE_CD to determine the type used for each line.

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TAX_NUM

LABEL: Line Provider Tax Number

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

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

SHORT NAME: TAX_NUM

LONG NAME: TAX_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: -

COMMENT: -

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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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TYPSRVCB

LABEL: Line CMS Type Service Code

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

SHORT NAME: TYPSRVCB

LONG NAME: LINE_CMS_TYPE_SRVC_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

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

COMMENT: -

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UNIT_IND

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

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

SHORT NAME: UNIT_IND

LONG NAME: DMERC_LINE_MTUS_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CWF

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

NOTE: It was recently discovered that this problem has been corrected -- no date on when the correction became effective.

COMMENT: -

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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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