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CODEBOOK:
Master Beneficiary Summary File (MBSF) Other Chronic or Potentially Disabling Conditions Segment

FEBRUARY 2024 | VERSION 1.5

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Revision Log

Date	Changed by	Revisions	Version
February 2024	A. Sisco	Clarified name of the depression condition	1.5
February 2021	C. Alleman K. Russell	Migrated codebook to 2020 document template	1.4
June 2019	J. Burton	Added sickle cell disease condition	1.3
August 2018	C. Alleman K. Schneider	Added opioid use disorder conditions	1.2
August 2017	K. Schneider	Added the alcohol and drug abuse conditions	1.1
May 2017	C. Alleman K. Schneider	Initial release of codebook for the Master Beneficiary Summary File — Other Chronic or Potentially Disabling Conditions Segment	1.0

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the Medicare Beneficiary Summary File (MBSF) — Other Chronic or Potentially Disabling Conditions Segment research files. We have included several ways for users to quickly find the information they need:

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

Hyperlinks are included throughout the codebook to make it easier for users to navigate between the table of contents and the detailed entries for the individual variables:

- Clicking on any variable name in the Table of Contents will take you to the detailed description for that variable.
- From the detailed description for any individual variable, clicking on the ^Back to TOC^ link after each variable description will take you back to the Table of Contents.

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Variable Details

This section of the Codebook contains one entry for each variable in the Medicare Beneficiary Summary File (MBSF) Other Chronic or Potentially Disabling Conditions segment files. Each entry contains variable details to facilitate understanding and use of the variables.

ACP_MEDICARE

LABEL: ADHD and Other Conduct Disorders Indicator – Medicare Only Data

DESCRIPTION: This code specifies whether the enrollee met the chronic condition algorithm criteria, considering only Medicare data, for having attention deficit hyperactivity disorder (ADHD) or other conduct disorders as of the end of the calendar year.

SHORT NAME: ACP_MEDICARE

LONG NAME: ACP_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The CCW's other chronic or potentially disabling condition variables require enrollees to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (FFS Medicare Part A and Part B coverage during the entire specified time period).

For ADHD and other conduct disorders, beneficiaries must have at least one inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the algorithm criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

ACP_MEDICARE_EVER

LABEL: ADHD and Other Conduct Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the attention deficit hyperactivity disorder (ADHD) or other conduct disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: ACP_MEDICARE_EVER

LONG NAME: ACP_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

ALCO_MEDICARE

LABEL: Alcohol Use Disorders Indicator — Medicare Only Data

DESCRIPTION: This code specifies whether the enrollee met the chronic condition algorithm criteria, considering only Medicare data, for having alcohol use disorder as of the end of the calendar year.

SHORT NAME: ALCO_MEDICARE

LONG NAME: ALCO_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The CCW's other chronic or potentially disabling condition variables require enrollees to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (FFS Medicare Part A and Part B coverage during the entire specified time period).

For alcohol use disorders, beneficiaries must have at least one inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the algorithm criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

ALCO_MEDICARE_EVER

LABEL: Alcohol Use Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the alcohol use disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: ALCO_MEDICARE_EVER

LONG NAME: ALCO_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

ANXI_MEDICARE

LABEL: Anxiety Disorders Indicator — Medicare Only Data

DESCRIPTION: This variable indicates whether the enrollee met the chronic condition algorithm criteria, considering only Medicare data, for anxiety disorders as of the end of the calendar year.

SHORT NAME: ANXI_MEDICARE

LONG NAME: ANXI_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The CCW's other chronic or potentially disabling condition variables require enrollees to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For anxiety disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

ANXI_MEDICARE_EVER

LABEL: Anxiety Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the anxiety disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: ANXI_MEDICARE_EVER

LONG NAME: ANXI_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

AUTISM_MEDICARE

LABEL: Autism Spectrum Disorders Indicator — Medicare Only Data

DESCRIPTION: This variable indicates whether the enrollee met the chronic condition algorithm criteria, considering only Medicare data, for autism spectrum disorders as of the end of the calendar year.

SHORT NAME: AUTISM_MEDICARE

LONG NAME: AUTISM_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The CCW's other chronic or potentially disabling condition variables require enrollees to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For autism spectrum disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

AUTISM_MEDICARE_EVER

LABEL: Autism Spectrum Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the autism spectrum disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: AUTISM_MEDICARE_EVER

LONG NAME: AUTISM_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

BIPL_MEDICARE

LABEL: Bipolar Disorder Indicator — Medicare Only Data

DESCRIPTION: This variable indicates whether the enrollee met the chronic condition algorithm criteria, considering only Medicare data, for bipolar disorders as of the end of the calendar year.

SHORT NAME: BIPL_MEDICARE

LONG NAME: BIPL_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The CCW's other chronic or potentially disabling condition variables require enrollees to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For bipolar disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

BIPL_MEDICARE_EVER

LABEL: Bipolar Disorder First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the bipolar disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: BIPL_MEDICARE_EVER

LONG NAME: BIPL_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

BRAINJ_MEDICARE

LABEL: Traumatic Brain Injury and Nonpsychotic Mental Disorders due to Brain Damage End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for traumatic brain injury and nonpsychotic mental disorders as of the end of the calendar year.

SHORT NAME: BRAINJ_MEDICARE

LONG NAME: BRAINJ_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For traumatic brain injury and nonpsychotic mental disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

BRAINJ_MEDICARE_EVER

LABEL: Traumatic Brain Injury and Nonpsychotic Mental Disorders due to Brain Damage First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the traumatic brain injury and nonpsychotic mental disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: BRAINJ_MEDICARE_EVER

LONG NAME: BRAINJ_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

CERPAL_MEDICARE

LABEL: Cerebral Palsy End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for cerebral palsy as of the end of the calendar year.

SHORT NAME: CERPAL_MEDICARE

LONG NAME: CERPAL_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For cerebral palsy, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

CERPAL_MEDICARE_EVER

LABEL: Cerebral Palsy First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the cerebral palsy indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: CERPAL_MEDICARE_EVER

LONG NAME: CERPAL_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

CYSFIB_MEDICARE

LABEL: Cystic Fibrosis and Other Metabolic Developmental Disorders End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for cystic fibrosis and other metabolic developmental disorders as of the end of the calendar year.

SHORT NAME: CYSFIB_MEDICARE

LONG NAME: CYSFIB_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For cystic fibrosis and other metabolic developmental disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

CYSFIB_MEDICARE_EVER

LABEL: Cystic Fibrosis and Other Metabolic Developmental Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the cystic fibrosis and other metabolic developmental disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: CYSFIB_MEDICARE_EVER

LONG NAME: CYSFIB_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

DEPSN_MEDICARE

LABEL: Major Depressive Disorders End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for major depressive disorders as of the end of the calendar year. (On the CCW website, we shorten this condition label to "Depressive Disorders" for simplicity.)

SHORT NAME: DEPSN_MEDICARE

LONG NAME: DEPSN_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For major depressive disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

NOTE: This depressive disorders condition definition is slightly different than the CCW depression condition; this depressive affective disorder condition was specified by CMS to enhance research of the Medicare-Medicaid dually enrolled population.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

DEPSN_MEDICARE_EVER

LABEL: Major Depressive Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the major depressive disorders indicator. The variable will be blank for beneficiaries that have never had the condition. (On the CCW website, we shorten this condition label to "Depressive Disorders" for simplicity.)

SHORT NAME: DEPSN_MEDICARE_EVER

LONG NAME: DEPSN_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

DRUG_MEDICARE

LABEL: Drug Use Disorders End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for drug use disorder as of the end of the calendar year.

SHORT NAME: DRUG_MEDICARE

LONG NAME: DRUG_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For drug use disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

DRUG_MEDICARE_EVER

LABEL: Drug Use Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the drug use disorder indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: DRUG_MEDICARE_EVER

LONG NAME: DRUG_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

ENRL_SRC

LABEL: Enrollment Source

DESCRIPTION: This variable indicates the source of enrollment data.

SHORT NAME: ENRL_SRC

LONG NAME: ENRL_SRC

TYPE: CHAR

LENGTH: 3

SOURCE: CCW

VALUES: EDB = Enrollment Database
CME = Common Medicare Environment

COMMENT: The Centers for Medicare & Medicaid Services (CMS) has updated the Medicare enrollment source data for the Master Beneficiary Summary File (MBSF). As of March 2017, the MBSF includes Medicare enrollment information from the CMS Common Medicare Environment (CME) rather than the Enrollment Database (EDB). Data from the two sources was nearly identical. The CME improves the identification of Medicare Part B enrollment and also allows for more timely release of the MBSF.

The universe of beneficiaries in the CME versus the EDB version of the MBSF are only slightly different.

EPILEP_MEDICARE

LABEL: Epilepsy End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for epilepsy as of the end of the calendar year.

SHORT NAME: EPILEP_MEDICARE

LONG NAME: EPILEP_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For epilepsy, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

EPILEP_MEDICARE_EVER

LABEL: Epilepsy First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the epilepsy indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: EPILEP_MEDICARE_EVER

LONG NAME: EPILEP_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

FIBRO_MEDICARE

LABEL: Fibromyalgia, Chronic Pain and Fatigue End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for fibromyalgia, chronic pain, and fatigue as of the end of the calendar year.

SHORT NAME: FIBRO_MEDICARE

LONG NAME: FIBRO_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For fibromyalgia, chronic pain and fatigue, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

FIBRO_MEDICARE_EVER

LABEL: Fibromyalgia, Chronic Pain and Fatigue First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the fibromyalgia, chronic pain, and fatigue indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: FIBRO_MEDICARE_EVER

LONG NAME: FIBRO_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

HEARIM_MEDICARE

LABEL: Sensory — Deafness and Hearing Impairment End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for a sensory (deafness and hearing) impairment as of the end of the calendar year.

SHORT NAME: HEARIM_MEDICARE

LONG NAME: HEARIM_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For sensory (deafness and hearing) impairment, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

HEARIM_MEDICARE_EVER

LABEL: Sensory — Deafness and Hearing Impairment First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for a sensory (deafness and hearing) impairment.

The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: HEARIM_MEDICARE_EVER

LONG NAME: HEARIM_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

HEPVIRAL_MEDICARE

LABEL: Viral Hepatitis (General) End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for viral hepatitis (general) as of the end of the calendar year.

SHORT NAME: HEPVIRAL_MEDICARE

LONG NAME: HEPVIRAL_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For viral hepatitis (general), beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

HEPVIRAL_MEDICARE_EVER

LABEL: Viral Hepatitis (General) First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the viral hepatitis (general) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: HEPVIRAL_MEDICARE_EVER

LONG NAME: HEPVIRAL_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

HIVAIDS_MEDICARE

LABEL: Human Immunodeficiency Virus and/or Acquired Immunodeficiency Syndrome (HIV/AIDS) End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for human immunodeficiency virus and/or acquired immunodeficiency syndrome (HIV/AIDS) as of the end of the calendar year.

SHORT NAME: HIVAIDS_MEDICARE

LONG NAME: HIVAIDS_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For human immunodeficiency virus and/or acquired immunodeficiency syndrome (HIV/AIDS), beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

HIVAIDS_MEDICARE_EVER

LABEL: Human Immunodeficiency Virus and/or Acquired Immunodeficiency Syndrome (HIV/AIDS) First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the human immunodeficiency virus and/or acquired immunodeficiency syndrome (HIV/AIDS) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: HIVAIDS_MEDICARE_EVER

LONG NAME: HIVAIDS_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

INTDIS_MEDICARE

LABEL: Intellectual Disabilities and Related Conditions End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for intellectual disabilities and related conditions as of the end of the calendar year.

SHORT NAME: INTDIS_MEDICARE

LONG NAME: INTDIS_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For intellectual disabilities and related conditions, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

INTDIS_MEDICARE_EVER

LABEL: Intellectual Disabilities and Related Conditions First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the intellectual disabilities and related conditions indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: INTDIS_MEDICARE_EVER

LONG NAME: INTDIS_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

LEADIS_MEDICARE

LABEL: Learning Disabilities End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for learning disabilities as of the end of the calendar year.

SHORT NAME: LEADIS_MEDICARE

LONG NAME: LEADIS_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For learning disabilities, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

LEADIS_MEDICARE_EVER

LABEL: Learning Disabilities First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the learning disabilities indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: LEADIS_MEDICARE_EVER

LONG NAME: LEADIS_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

LEUKLYMPH_MEDICARE

LABEL: Leukemias and Lymphomas End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for leukemias and lymphomas as of the end of the calendar year.

SHORT NAME: LEUKLYMPH_MEDICARE

LONG NAME: LEUKLYMPH_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For leukemias and lymphomas, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

LEUKLYMPH_MEDICARE_EVER

LABEL: Leukemias and Lymphomas First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the leukemias and lymphomas indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: LEUKLYMPH_MEDICARE_EVER

LONG NAME: LEUKLYMPH_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

LIVER_MEDICARE

LABEL: Liver Disease, Cirrhosis and Other Liver Conditions (excluding Hepatitis) End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for liver disease, cirrhosis, and other liver conditions (excluding hepatitis) as of the end of the calendar year.

SHORT NAME: LIVER_MEDICARE

LONG NAME: LIVER_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For liver disease, cirrhosis, and other liver conditions (excluding hepatitis), beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

LIVER_MEDICARE_EVER

LABEL: Liver Disease, Cirrhosis and Other Liver Conditions (excluding Hepatitis) First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the liver disease, cirrhosis, and other liver conditions (excluding hepatitis) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: LIVER_MEDICARE_EVER

LONG NAME: LIVER_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

MIGRAINE_MEDICARE

LABEL: Migraine and other Chronic Headache End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for migraine and other chronic headache as of the end of the calendar year.

SHORT NAME: MIGRAINE_MEDICARE

LONG NAME: MIGRAINE_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For migraine and other chronic headache, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

MIGRAINE_MEDICARE_EVER

LABEL: Migraine and other Chronic Headache First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the migraine and other chronic headache indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: MIGRAINE_MEDICARE_EVER

LONG NAME: MIGRAINE_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

MOBIMP_MEDICARE

LABEL: Mobility Impairments End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for mobility impairments as of the end of the calendar year.

SHORT NAME: MOBIMP_MEDICARE

LONG NAME: MOBIMP_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For mobility impairments, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

MOBIMP_MEDICARE_EVER

LABEL: Mobility Impairments First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the mobility impairments indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: MOBIMP_MEDICARE_EVER

LONG NAME: MOBIMP_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

MULSCL_MEDICARE

LABEL: Multiple Sclerosis and Transverse Myelitis End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for multiple sclerosis and transverse myelitis as of the end of the calendar year.

SHORT NAME: MULSCL_MEDICARE

LONG NAME: MULSCL_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For multiple sclerosis and transverse myelitis, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

MULSCL_MEDICARE_EVER

LABEL: Multiple Sclerosis and Transverse Myelitis First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the multiple sclerosis and transverse myelitis indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: MULSCL_MEDICARE_EVER

LONG NAME: MULSCL_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

MUSDYS_MEDICARE

LABEL: Muscular Dystrophy End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for muscular dystrophy as of the end of the calendar year.

SHORT NAME: MUSDYS_MEDICARE

LONG NAME: MUSDYS_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For muscular dystrophy, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

MUSDYS_MEDICARE_EVER

LABEL: Muscular Dystrophy First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the muscular dystrophy indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: MUSDYS_MEDICARE_EVER

LONG NAME: MUSDYS_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

OBESITY_MEDICARE

LABEL: Obesity End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for obesity as of the end of the calendar year.

SHORT NAME: OBESITY_MEDICARE

LONG NAME: OBESITY_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For obesity, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

OBESITY_MEDICARE_EVER

LABEL: Obesity First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the obesity indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: OBESITY_MEDICARE_EVER

LONG NAME: OBESITY_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

OTHDEL_MEDICARE

LABEL: Other Developmental Delays End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for other developmental delays as of the end of the calendar year.

SHORT NAME: OTHDEL_MEDICARE

LONG NAME: OTHDEL_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For other developmental delays, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

OTHDEL_MEDICARE_EVER

LABEL: Other Developmental Delays First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the other developmental delays' indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: OTHDEL_MEDICARE_EVER

LONG NAME: OTHDEL_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

OUD_ANY_MEDICARE

LABEL: Overarching OUD Disorder (Any of the Three Sub-Indicators) — Medicare Only Claims

DESCRIPTION: This variable is the Overarching Opioid Use Disorder (OUD) indicator, which identifies whether a beneficiary met any of the three opioid-related sub-Indicators as of the end of the calendar year. Beneficiaries who were identified as meeting the criteria for any of the following, also meet the criteria for this overarching indicator: OUD_DX_MEDICARE, OUD_HOSP_MEDICARE, or OUD_MAT_MEDICARE.

SHORT NAME: OUD_ANY_MEDICARE

LONG NAME: OUD_ANY_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For the overarching opioid use disorder indicator, beneficiaries must have met the criteria for at least one of the three opioid-use disorder sub-category conditions:

Diagnosis and Procedure Basis for OUD (OUD_DX_MEDICARE),

Opioid-Related Hospitalization or ED (OUD_HOSP_MEDICARE), or

Use of Medication-Assisted Treatment (MAT) (OUD_MAT_MEDICARE).

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

OUD_ANY_MEDICARE_EVER

LABEL: Overarching OUD Disorder (Any of the Three Sub-Indicators) First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Overarching opioid use disorder (OUD) condition indicator (Any of the Three Sub-Indicators). The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: OUD_ANY_MEDICARE_EVER

LONG NAME: OUD_ANY MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

For the overarching opioid use disorder indicator, beneficiaries must have met the criteria for at least one of the three opioid-use disorder sub-category conditions, and therefore had the corresponding "*_EVER" variable populated:

Diagnosis and Procedure Basis for OUD — First Ever Occurrence Date (OUD_DX_MEDICARE_EVER),

Opioid-Related Hospitalization or ED — First Ever Occurrence Date (OUD_HOSP_MEDICARE_EVER), or

Use of Medication-Assisted Treatment (MAT) — First Ever Occurrence Date (OUD_MAT_MEDICARE_EVER).

OUD_DX_MEDICARE

LABEL: Diagnosis and Procedure Basis for OUD — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the Diagnosis and Procedure Basis for Opioid Use Disorder (OUD) as of the end of the calendar year.

SHORT NAME: OUD_DX_MEDICARE

LONG NAME: OUD_DX _MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For opioid use disorder, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

OUD_DX_MEDICARE_EVER

LABEL: Diagnosis and Procedure Basis for OUD First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the opioid use disorder (OUD) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: OUD_DX_MEDICARE_EVER

LONG NAME: OUD_DX MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

OUD_HOSP_MEDICARE

LABEL: Opioid-Related Hospitalization or ED — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the criteria for Opioid-Related Hospitalization or emergency department (ED) visits as of the end of the calendar year.

SHORT NAME: OUD_HOSP_MEDICARE

LONG NAME: OUD_HOSP _MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For opioid-related hospitalization or ED visits, beneficiaries must have at least one Medicare inpatient claim or one emergency department claim with a related code in any position during the two-year reference period.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

OUD_HOSP_MEDICARE_EVER

LABEL: Opioid-Related Hospitalization or ED First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Opioid-Related Hospitalization or emergency department (ED) visit indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: OUD_HOSP_MEDICARE_EVER

LONG NAME: OUD_HOSP_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

OUD_MAT_MEDICARE

LABEL: Use of Medication-Assisted Treatment (MAT) — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the criteria for the Use of Medication-Assisted Treatment (MAT) as of the end of the calendar year.

SHORT NAME: OUD_MAT_MEDICARE

LONG NAME: OUD_MAT _MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES:
0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For use of Medication-Assisted Treatment (MAT), beneficiaries must have one or more drug claim (Medicare Part B, Medicare Part D, and/or Medicaid) with an NDC (national drug code) for opioid-MAT or one or more non-drug claim (Medicare Part B or Medicaid non-drug claim) with a HCPCs code during the two-year period.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

OUD_MAT_MEDICARE_EVER

LABEL: Use of Medication-Assisted Treatment (MAT) First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the utilization of Medication-Assisted Treatment (MAT) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: OUD_MAT_MEDICARE_EVER

LONG NAME: OUD_MAT MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

PSDS_MEDICARE

LABEL: Personality Disorders End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for personality disorders as of the end of the calendar year.

SHORT NAME: PSDS_MEDICARE

LONG NAME: PSDS_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For personality disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

PSDS_MEDICARE_EVER

LABEL: Personality Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the personality disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: PSDS_MEDICARE_EVER

LONG NAME: PSDS_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

PTRA_MEDICARE

LABEL: Post-Traumatic Stress Disorder End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for post-traumatic stress disorder as of the end of the calendar year.

SHORT NAME: PTRA_MEDICARE

LONG NAME: PTRA_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For post-traumatic stress disorder, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

PTRA_MEDICARE_EVER

LABEL: Post-Traumatic Stress Disorder First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the post-traumatic stress disorder indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: PTRA_MEDICARE_EVER

LONG NAME: PTRA_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

PVD_MEDICARE

LABEL: Peripheral Vascular Disease End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for peripheral vascular disease as of the end of the calendar year.

SHORT NAME: PVD_MEDICARE

LONG NAME: PVD_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For peripheral vascular disease, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

PVD_MEDICARE_EVER

LABEL: Peripheral Vascular Disease First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the peripheral vascular disease indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: PVD_MEDICARE_EVER

LONG NAME: PVD_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

SCD_MEDICARE

LABEL: Sickle Cell Disease End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for sickle cell disease as of the end of the calendar year.

SHORT NAME: SCD_MEDICARE

LONG NAME: SCD_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For sickle cell disease, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the five-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

SCD_MEDICARE_EVER

LABEL: Sickle Cell Disease First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the sickle cell disease indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: SCD_MEDICARE_EVER

LONG NAME: SCD_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

SCHI_MEDICARE

LABEL: Schizophrenia End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for schizophrenia as of the end of the calendar year.

SHORT NAME: SCHI_MEDICARE

LONG NAME: SCHI_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For schizophrenia, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

SCHI_MEDICARE_EVER

LABEL: Schizophrenia First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the schizophrenia indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: SCHI_MEDICARE_EVER

LONG NAME: SCHI_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

SCHIOT_MEDICARE

LABEL: Schizophrenia and Other Psychotic Disorders End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for schizophrenia and other psychotic disorders as of the end of the calendar year.

SHORT NAME: SCHIOT_MEDICARE

LONG NAME: SCHIOT_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For schizophrenia and other psychotic disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

SCHIOT_MEDICARE_EVER

LABEL: Schizophrenia and Other Psychotic Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the schizophrenia and other psychotic disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: SCHIOT_MEDICARE_EVER

LONG NAME: SCHIOT_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

SPIBIF_MEDICARE

LABEL: Spina Bifida and Other Congenital Anomalies of the Nervous System End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for spina bifida and other congenital anomalies of the nervous system as of the end of the calendar year.

SHORT NAME: SPIBIF_MEDICARE

LONG NAME: SPIBIF_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For spina bifida and other congenital anomalies of the nervous system, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

SPIBIF_MEDICARE_EVER

LABEL: Spina Bifida and Other Congenital Anomalies of the Nervous System First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the spina bifida and other congenital anomalies of the nervous system indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: SPIBIF_MEDICARE_EVER

LONG NAME: SPIBIF_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

SPIINJ_MEDICARE

LABEL: Spinal Cord Injury End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for spinal cord injury as of the end of the calendar year.

SHORT NAME: SPIINJ_MEDICARE

LONG NAME: SPIINJ_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For spinal cord injury, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

SPIINJ_MEDICARE_EVER

LABEL: Spinal Cord Injury First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the spinal cord injury indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: SPIINJ_MEDICARE_EVER

LONG NAME: SPIINJ_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

TOBA_MEDICARE

LABEL: Tobacco Use Disorders End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for tobacco use disorders as of the end of the calendar year.

SHORT NAME: TOBA_MEDICARE

LONG NAME: TOBA_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For tobacco use disorders, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website: https://www.ccwdata.org/web/guest/condition-categories

TOBA_MEDICARE_EVER

LABEL: Tobacco Use Disorders First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the tobacco use disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: TOBA_MEDICARE_EVER

LONG NAME: TOBA_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

ULCERS_MEDICARE

LABEL: Pressure Ulcers and Chronic Ulcers End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for pressure ulcers and chronic ulcers as of the end of the calendar year.

SHORT NAME: ULCERS_MEDICARE

LONG NAME: ULCERS_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For pressure ulcers and chronic ulcers, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

ULCERS_MEDICARE_EVER

LABEL: Pressure Ulcers and Chronic Ulcers First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the pressure ulcers and chronic ulcers indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: ULCERS_MEDICARE_EVER

LONG NAME: ULCERS_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).

VISUAL_MEDICARE

LABEL: Sensory — Blindness and Visual Impairment End-of-Year Indicator — Medicare Only Claims

DESCRIPTION: This variable indicates whether a beneficiary met the condition criteria for sensory (blindness and visual) impairment as of the end of the calendar year.

SHORT NAME: VISUAL_MEDICARE

LONG NAME: VISUAL_MEDICARE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

VALUES: 0 = Beneficiary did not meet claims criteria or have sufficient fee-for-service (FFS) coverage
1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
3 = Beneficiary met claims criteria and had sufficient FFS coverage

COMMENT: The condition variable requires beneficiaries to satisfy both claims criteria (a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (Medicare FFS Part A and Part B coverage during the entire specified time period).

For sensory (blindness and visual) impairment, beneficiaries must have at least one Medicare inpatient claim or two other non-drug claims of any service type with a related code in any position during the two-year reference period. When two claims are required, they must occur at least one day apart.

You can find more detailed information on the criteria on the CCW website:
https://www.ccwdata.org/web/guest/condition-categories

VISUAL_MEDICARE_EVER

LABEL: Sensory — Blindness and Visual Impairment First Ever Occurrence Date — Medicare Only Claims

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the sensory (blindness and visual) impairment indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: VISUAL_MEDICARE_EVER

LONG NAME: VISUAL_MEDICARE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for anyone in the CCW is January 1, 1999. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Beneficiary File).