CMS RIF REPORT
AS OF: 09/17/2008

NAME	LENGTH	BEG	END	CONTENTS
*** FI HHA Claim Record (NCH)	VAR	1	12263	REC
				Fiscal intermediary home health agency claim record for Version I of the NCH. STANDARD ALIAS : FI_HHA_CLM_REC SYSTEM ALIAS : UTLHHAI LIMITATIONS : REFER TO : HHA_AB_SHIFT_LIM HHA_MISG_CLM_LIM HHA_PPS_LUPA_0023_LINE_LIM HHA_PPS_RIC_CD_ADJSTMT_LIM HHA_PTA_OVRLD_TRLR_LIM
1. FI HHA Claim Fixed Group	569	1	569	GRP
				Fixed portion of the fiscal intermediary home health agency claim record for Version 'I' of the NCH. STANDARD ALIAS : FI_HHA_CLM_FIX_GRP
2. Claim Record Identification Group	8	1	8	GRP
				Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing. STANDARD ALIAS : CLM_REC_IDENT_GRP
3. Record Length Count	3	1	3	PACK
				Effective with Version H, the count (in bytes) of the length of the claim record. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS : REC_LNGTH_CNT SAS ALIAS : REC_LEN STANDARD ALIAS : REC_LNGTH_CNT LENGTH : 5 SIGNED : Y SOURCE : NCH
4. NCH Near-Line Record Version Code	1	4	4	CHAR
				The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored. DB2 ALIAS : NCH_REC_VRSN_CD SAS ALIAS : REC_LVL STANDARD ALIAS : NCH_NEAR_LINE_REC_VRSN_CD

TITLE ALIAS : NCH_VERSION

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_REC_VRSN_TB

5. NCH Near Line Record Identification Code
1 5 5 CHAR

A code defining the type of claim record being processed.

COMMON ALIAS : RIC
DB2 ALIAS : NEAR_LINE_RIC_CD
SAS ALIAS : RIC_CD
STANDARD ALIAS : NCH_NEAR_LINE_RIC_CD
TITLE ALIAS : RIC

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: RIC_CD.

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_RIC_TB

6. NCH MQA RIC Code
1 6 6 CHAR

Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through CMS' CWFMQA system.

NOTE: Beginning with NCH weekly process date field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH_MQA_RIC_CD
SAS ALIAS : MQA_RIC
STANDARD ALIAS : NCH_MQA_RIC_CD
TITLE ALIAS : MQA_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH_MQA_RIC_TB

7. NCH Claim Type Code
2 7 8 CHAR

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).

DB2 ALIAS : NCH_CLM_TYPE_CD
SAS ALIAS : CLM TYPE

STANDARD ALIAS : NCH_CLM_TYPE_CD
TITLE ALIAS : CLAIM_TYPE

LENGTH : 2

DERIVATIONS :
FFS CLAIM TYPE CODES DERIVED FROM:
NCH CLM_NEAR_LINE_RIC_CD
NCH PMT_EDIT_RIC_CD
NCH CLM_TRANS_CD
NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)
CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO PRD EFCTV DT & MCO PRD TRMNTN DT

ENCOUNTER

WHERE THE

CLAIM)

or

the

DMERC

CLAIM)

or

the

ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL'

CLAIM -- EFFECTIVE WITH HDC PROCESSING)

FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS

WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one

more line item(s) match the HCPCS on

DMEPOS table).

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS

CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC

WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one

more line item(s) match the HCPCS on

DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH_CLM_TYPE_TB

8. Fiscal Intermediary Claim Link Group — 125 | 9 | 133 | GRP

Effective with Version 'I', this group contains those fields necessary to keep segments together (a claim may have up 10 segments due to the increase in number of revenue center trailers (up to 450). It is also used to house fields necessary for

sorting

and the final action process.

STANDARD ALIAS : FI_CLM_LINK_GRP

9. Claim Locator Number Group — 11 | 9 | 19 | GRP

This number uniquely identifies the

beneficiary in

the NCH Nearline.

COMMON ALIAS : HIC
STANDARD ALIAS : CLM_LCTR_NUM_GRP
TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number — 9 | 9 | 17 | CHAR

The number identifying the primary

beneficiary

under the SSA or RRB programs submitted.

COMMON ALIAS : CAN
DB2 ALIAS : BENE_CLM_ACNT_NUM
SAS ALIAS : CAN
STANDARD ALIAS : BENE_CLM_ACNT_NUM
TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :
RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.

11. NCH Category Equatable Beneficiary Identification Code

2	18	19	CHAR

The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

COMMON ALIAS : NCH_BASE_CATEGORY_BIC
DB2 ALIAS : CTGRY_EQTBL_BIC
SAS ALIAS : EQ_BIC
STANDARD ALIAS : NCH_CTGRY_EQTBL_BIC_CD
TITLE ALIAS : EQUATED_BIC

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: CTGRY_EQTBL_BENE_IDENT_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY_EQTBL_BENE_IDENT_TB

12. Beneficiary Identification Code

2	20	21	CHAR

The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

COMMON ALIAS : BIC
DA3 ALIAS : BENE_IDENT_CODE
DB2 ALIAS : BENE_IDENT_CD
SAS ALIAS : BIC
STANDARD ALIAS : BENE_IDENT_CD
TITLE ALIAS : BIC

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :
EDB REQUIRED FIELD

CODE TABLE : BENE_IDENT_TB

13. NCH State Segment Code

1	22	22	CHAR

The code identifying the segment of the NCH

Nearline file

specific service

CLM_LCTR_NUM,

state. (Prior

county codes within

containing the beneficiary's record for a

year. Effective 12/96, segmentation is by

then final action sequence within residence

to 12/96, segmentation was by ranges of

the residence state.)

DB2 ALIAS : NCH_STATE_SGMT_CD
SAS ALIAS : ST_SGMT
STANDARD ALIAS : NCH_STATE_SGMT_CD
TITLE ALIAS : NEAR_LINE_SEGMENT

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: BENE_STATE_SGMT_NEAR_LINE_CD.

SOURCE : NCH

CODE TABLE : NCH_STATE_SGMT_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

The SSA standard state code of a

beneficiary's residence.

DA3 ALIAS : SSA_STANDARD_STATE_CODE
DB2 ALIAS : BENE_SSA_STATE_CD
SAS ALIAS : STATE_CD
STANDARD ALIAS : BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS : BENE_STATE_CD

LENGTH : 2

COMMENTS :
1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.
2. Concerning individuals directly billable

for

Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE : SSA/EDB

EDIT RULES :
OPTIONAL: MAY BE BLANK

CODE TABLE : GEO_SSA_STATE_TB

15. Claim From Date

8 25 32 NUM

The first day on the billing statement covering services rendered to the bene-

ficiary (a.k.a. 'Statement Covers From

Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM_FROM_DT
SAS ALIAS : FROM_DT
STANDARD ALIAS : CLM_FROM_DT
TITLE ALIAS : FROM_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

16. Claim Through Date

8 33 40 NUM

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

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM_THRU_DT
SAS ALIAS : THRU_DT
STANDARD ALIAS : CLM_THRU_DT
TITLE ALIAS : THRU_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

17. NCH Weekly Claim Processing Date

8 41 48 NUM

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.

DB2 ALIAS : NCH_WKLY_PROC_DT
SAS ALIAS : WKLY_DT
STANDARD ALIAS : NCH_WKLY_PROC_DT
TITLE ALIAS : NCH_PROCESS_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version H this field was named: HCFA_CLM_PROC_DT.

SOURCE : NCH

EDIT RULES :
YYYYMMDD

18. CWF Claim Accretion Date

8 49 56 NUM

The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal interme-diary or carrier.

DB2 ALIAS : CWF_CLM_ACRTN_DT
SAS ALIAS : ACRTN_DT
STANDARD ALIAS : CWF_CLM_ACRTN_DT
TITLE ALIAS : ACCRETION_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

19. CWF Claim Accretion Number

2 57 58 PACK

The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates

the position of the claim within that day's processing at the CWF host. **(Exception: If the claim record is missing the accretion

date

CMS' CWFMQA system places a zero in the accretion number.

DB2 ALIAS : CWF_CLM_ACRTN_NUM
SAS ALIAS : ACRTN_NM
STANDARD ALIAS : CWF_CLM_ACRTN_NUM
TITLE ALIAS : ACCRETION_NUMBER

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. FI Document Claim Control Number

23 59 81 CHAR

Unique control number assigned by an intermediary to an institutional claim.

COMMON ALIAS : ICN
DB2 ALIAS : DOC_CLM_CNTL_NUM
SAS ALIAS : CLM_CNTL
STANDARD ALIAS : FI_DOC_CLM_CNTL_NUM
TITLE ALIAS : ICN

LENGTH : 23

SOURCE : CWF

21. FI Original Claim Control Number

23 82 104 CHAR

Effective with Version G, the original

intermediary

control number (ICN) which is present on

adjustment

claims, representing the ICN of the original transaction now being adjusted.

COMMON ALIAS : ORIGINAL_ICN
DB2 ALIAS : ORIG_CLM_CNTL_NUM
SAS ALIAS : ORIGCNTL
STANDARD ALIAS : FI_ORIG_CLM_CNTL_NUM
TITLE ALIAS : ORIGINAL_ICN

LENGTH : 23

SOURCE : CWF

22. Claim Query Code

1 105 105 CHAR

Code indicating the type of claim record

being processed

with respect to payment (debit/credit

indicator;

interim/final indicator).

DB2 ALIAS : CLM_QUERY_CD
SAS ALIAS : QUERY_CD
STANDARD ALIAS : CLM_QUERY_CD
TITLE ALIAS : QUERY_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_QUERY_TB

23. Provider Number

6 106 111 CHAR

The identification number of the

institutional provider

certified by Medicare to provide services to

the

beneficiary.

Provider

Identifier

and

NOTE: Effective October 1, 2007 the OSCAR

Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider

(NPI). The CCN (OSCAR Provider Number) will continue to play a critical role in verifying that a provider has been Medicare certified

for what type of services.

DB2 ALIAS : PRVDR_NUM
SAS ALIAS : PROVIDER
STANDARD ALIAS : PRVDR_NUM
TITLE ALIAS : PROVIDER_NUMBER

LENGTH : 6

CODE TABLE : PRVDR_NUM_TB

24. NCH Daily Process Date — 8 — 112 — 119 — NUM

record was

internal editing

in conjunction

claims with

populated with

10/3/97.

that were

a date.

Effective with Version H, the date the claim

processed by CMS' CWFMQA system (used for

purposes).

Effective with Version I, this date is used

with the NCH Segment Link Number to keep

multiple records/ segments together.

NOTE1: With Version 'H' this field was

data beginning with NCH weekly process date

Under Version 'I' claims prior to 10/3/97,

blank under Version 'H', were populated with

DB2 ALIAS : NCH_DAILY_PROC_DT
SAS ALIAS : DAILY_DT
STANDARD ALIAS : NCH_DAILY_PROC_DT
TITLE ALIAS : DAILY_PROCESS_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :
YYYYMMDD

25. NCH Segment Link Number — 5 — 120 — 124 — PACK

Effective with Version 'I', the system gen-erated number used in conjunction with the NCH daily process date to keep

records/segments

belonging to a specific claim together. This field was added to ensure that records/ segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH_SGMT_LINK_NUM
SAS ALIAS : LINK_NUM
STANDARD ALIAS : NCH_SGMT_LINK_NUM
TITLE ALIAS : LINK_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

26. Claim Total Segment Count

2 125 126 NUM

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

DB2 ALIAS : TOT_SGMT_CNT
SAS ALIAS : SGMT_CNT
STANDARD ALIAS : CLM_TOT_SGMT_CNT
TITLE ALIAS : SEGMENT_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

27. Claim Segment Number

2 127 128 NUM

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.

DB2 ALIAS : CLM_SGMT_NUM
SAS ALIAS : SGMT_NUM
STANDARD ALIAS : CLM_SGMT_NUM
TITLE ALIAS : SEGMENT_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Claim Total Line Count

3 129 131 NUM

Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.

DB2 ALIAS : TOT_LINE_CNT
SAS ALIAS : LINECNT
STANDARD ALIAS : CLM_TOT_LINE_CNT
TITLE ALIAS : TOTAL_LINE_COUNT

LENGTH : 3 SIGNED : N

SOURCE : CWF

29. Claim Segment Line Count

2 132 133 NUM

Effective with Version I, the count used

to identify the number of lines on a record/ segment.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.

DB2 ALIAS : SGMT_LINE_CNT
SAS ALIAS : SGMTLINE
STANDARD ALIAS : CLM_SGMT_LINE_CNT
TITLE ALIAS : SEGMENT_LINE_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

30. FI Claim Common Group

359	134	492	GRP

Information common to fiscal intermediary (FI) claims (inpatient/SNF, outpatient, HHA & hospice), for version I of NCH Nearline file.

STANDARD ALIAS : FI_CLM_CMN_GRP

31. NCH Payment and Edit Record Identification Code

1	134	134	CHAR

The code used for payment and editing purposes that indicates the type of institutional claim record.

Prior to Version H this field was named: PMT_EDIT_RIC_CD.

DB2 ALIAS : PMT_EDIT_RIC_CD
SAS ALIAS : PE_RIC
STANDARD ALIAS : NCH_PMT_EDIT_RIC_CD
TITLE ALIAS : NCH_PAYMENT_EDIT_RIC

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : PMT_EDIT_RIC_TB

32. Claim Transaction Code

1	135	135	CHAR

The code derived by CWF to indicate the type of claim submitted by an institutional provider.

DB2 ALIAS : CLM_TRANS_CD
SAS ALIAS : TRANS_CD
STANDARD ALIAS : CLM_TRANS_CD
TITLE ALIAS : TRANSACTION_CODE

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :
CLM_TRANS_CD_LIM

CODE TABLE : CLM_TRANS_TB

33. Claim Bill Type Group

2	136	137	GRP

Effective with Version H, the claim facility

type code plus
(The first two
the Version H
throughout history.

was

the claim service classification type code.
positions of the ('type of bill'). During
conversion, this grouping was created

NOTE: Effective 4/1/2002, TOB code 'XX0'
implemented to identify those claims that are totally non-covered.

STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP

CODE TABLE : CLM_BILL_TYPE_TB

34. Claim Facility Type Code

1	136	136	CHAR

submitted on an
of facility

The first digit of the type of bill (TOB1)
institutional claim used to identify the type
that provided care to the beneficiary.

COMMON ALIAS : TOB1
DB2 ALIAS : CLM_FAC_TYPE_CD
SAS ALIAS : FAC_TYPE
STANDARD ALIAS : CLM_FAC_TYPE_CD
TITLE ALIAS : TOB1

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_FAC_TYPE_TB

35. Claim Service Classification Type Code

1	137	137	CHAR

submitted on an
classification of
beneficiary.

The second digit of the type of bill (TOB2)
institutional claim record to indicate the
the type of service provided to the

COMMON ALIAS : TOB2
DB2 ALIAS : SRVC_CLSFCTN_CD
SAS ALIAS : TYPESRVC
STANDARD ALIAS : CLM_SRVC_CLSFCTN_TYPE_CD
TITLE ALIAS : TOB2

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_SRVC_CLSFCTN_TYPE_TB

36. Claim Frequency Code

1	138	138	CHAR

submitted on an
sequence of a
care.

The third digit of the type of bill (TOB3)
institutional claim record to indicate the
claim in the beneficiary's current episode of

COMMON ALIAS : TOB3
DB2 ALIAS : CLM_FREQ_CD
SAS ALIAS : FREQ_CD
STANDARD ALIAS : CLM_FREQ_CD
TITLE ALIAS : FREQUENCY_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM FREQ TB

37. FILLER 1 139 139 CHAR

DB2 ALIAS : FILLER

LENGTH : 1

38. NCH MQA Query Patch Code 1 140 140 CHAR

Effective with Version H, a code used (for purposes) to indicate that the CWFMQA process query code submitted on the claim record.

NOTE: Beginning with NCH weekly process date field was populated with data. Claims prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MQA_QUERY_PATCH_CD
SAS ALIAS : MQAQUERY
STANDARD ALIAS : NCH_MQA_QUERY_PATCH_CD
TITLE ALIAS : MQA_QUERY_PATCH_IND

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_MQA_QUERY_PATCH_TB

39. Claim Disposition Code 2 141 142 CHAR

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

DB2 ALIAS : CLM_DISP_CD
SAS ALIAS : DISP_CD
STANDARD ALIAS : CLM_DISP_CD
TITLE ALIAS : DISPOSITION_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_DISP_TB

40. NCH Edit Disposition Code 2 143 144 CHAR

Effective with Version H, a code used (for purposes) to indicate the disposition of the internal editing in the CWFMQA process.

NOTE: Beginning with NCH weekly process date field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH_EDIT_DISP_CD
SAS ALIAS : EDITDISP
STANDARD ALIAS : NCH_EDIT_DISP_CD
TITLE ALIAS : NCH_EDIT_DISP

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH_EDIT_DISP_TB

41. NCH Claim BIC Modify H Code 1 145 145 CHAR

internal
that was
BIC.

10/3/97 this
processed
field.

Effective with Version H, the code used (for editing purposes) to identify a claim record submitted with an incorrect HA, HB, or HC

NOTE: Beginning with NCH weekly process date field was populated with data. Claims prior to 10/3/97 will contain spaces in this

DB2 ALIAS : NCH_BIC_MDFY_CD
SAS ALIAS : BIC_MDFY
STANDARD ALIAS : NCH_CLM_BIC_MDFY_CD
TITLE ALIAS : BIC_MODIFY_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_CLM_BIC_MDFY_TB

42. Beneficiary Residence SSA Standard County Code

3	146	148	CHAR

The SSA standard county code of a beneficiary's residence.

DB2 ALIAS : BENE_SSA_CNTY_CD
SAS ALIAS : CNTY_CD
STANDARD ALIAS : BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS : BENE_COUNTY_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :
OPTIONAL: MAY BE BLANK

43. FI Claim Receipt Date

8	149	156	NUM

The date the fiscal intermediary received the institutional claim from the provider.

DB2 ALIAS : FI_CLM_RCPT_DT
SAS ALIAS : RCPT_DT
STANDARD ALIAS : FI_CLM_RCPT_DT
TITLE ALIAS : RECEIPT_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version H this field was named: FICARR_CLM_RCPT_DT.

SOURCE : CWF

EDIT RULES :
YYYYMMDD

44. FI Claim Scheduled Payment Date

8	157	164	NUM

The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

DB2 ALIAS : FI_SCHLD_PMT_DT
SAS ALIAS : SCHLD_DT
STANDARD ALIAS : FI_CLM_SCHLD_PMT_DT
TITLE ALIAS : SCHEDULED_PMT_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version H this field was named: FICARR_CLM_PMT_DT.

SOURCE : CWF

EDIT RULES :
YYYYMMDD

45. CWF Forwarded Date

8 165 172 NUM

Effective with Version H, the date CWF

forwarded the claim

record to CMS (used for internal editing

purposes).

NOTE: Beginning with NCH weekly process date

10/3/97 this

field was populated with data. Claims

processed

prior to 10/3/97 will contain zeroes in this

field.

DB2 ALIAS : CWF_FRWRD_DT
SAS ALIAS : FRWRD_DT
STANDARD ALIAS : CWF_FRWRD_DT
TITLE ALIAS : FORWARD_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

46. FI Number

5 173 177 CHAR

The identification number assigned by CMS to

a fiscal

intermediary authorized to process

institutional claim

records.

Effective October 2006, the Medicare

Administrative

Contractors (MACs) began replacing the

existing

fiscal intermediaries and started processing

institu-

tional claim records for states assigned to

its

jurisdiction.

NOTE: The 5-position MAC number will be

housed in

the existing FI_NUM field. During the

transition

from an FI to a MAC the FI_NUM field could

contain

either a FI number or a MAC number. See the FI_NUM table of codes to identify the new

MAC

numbers and their effective dates.

DB2 ALIAS : FI_NUM
SAS ALIAS : FI_NUM
STANDARD ALIAS : FI_NUM
TITLE ALIAS : INTERMEDIARY

LENGTH : 5

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

SOURCE : CWF

CODE TABLE : FI NUM TB

47. CWF Claim Assigned Number
8 178 185 CHAR

Effective with Version H, the number assigned to an institutional claim record by CWF (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : CWF_CLM_ASGN_NUM
SAS ALIAS : ASGN_NUM
STANDARD ALIAS : CWF_CLM_ASGN_NUM
TITLE ALIAS : ASSIGNED_NUM

LENGTH : 8

SOURCE : CWF

48. CWF Transmission Batch Number
4 186 189 CHAR

Effective with Version H, the number assigned to each batch of claims transactions sent from

CWF(used for internal editing purposes).

NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field.

DB2 ALIAS : TRNSMSN_BATCH_NUM
SAS ALIAS : FIBATCH
STANDARD ALIAS : CWF_TRNSMSN_BATCH_NUM
TITLE ALIAS : BATCH_NUM

LENGTH : 4

SOURCE : CWF

49. Beneficiary Mailing Contact ZIP Code
9 190 198 CHAR

The ZIP code of the mailing address where the

beneficiary may be contacted.

DB2 ALIAS : BENE_MLG_ZIP_CD
SAS ALIAS : BENE_ZIP
STANDARD ALIAS : BENE_MLG_CNTCT_ZIP_CD
TITLE ALIAS : BENE_ZIP

LENGTH : 9

SOURCE : EDB

50. Beneficiary Sex Identification Code
1 199 199 CHAR

The sex of a beneficiary.

COMMON ALIAS : SEX_CD
DA3 ALIAS : SEX_CODE
DB2 ALIAS : BENE_SEX_IDENT_CD
SAS ALIAS : SEX
STANDARD ALIAS : BENE_SEX_IDENT_CD
TITLE ALIAS : SEX_CD

LENGTH : 1

SOURCE : SSA,RRB,EDB

EDIT RULES :
REQUIRED FIELD

CODE TABLE : BENE_SEX_IDENT_TB

51. Beneficiary Race Code

1	200	200	CHAR

The race of a beneficiary.

DA3 ALIAS : RACE_CODE
DB2 ALIAS : BENE_RACE_CD
SAS ALIAS : RACE
STANDARD ALIAS : BENE_RACE_CD
TITLE ALIAS : RACE_CD

LENGTH : 1

SOURCE : SSA

CODE TABLE : BENE_RACE_TB

52. Beneficiary Birth Date

8	201	208	NUM

The beneficiary's date of birth.

COMMON ALIAS : DOB
DA3 ALIAS : BIRTH_DATE
DB2 ALIAS : BENE_BIRTH_DT
SAS ALIAS : BENE_DOB
STANDARD ALIAS : BENE_BIRTH_DT
TITLE ALIAS : BENE_BIRTH_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

53. CWF Beneficiary Medicare Status Code

2	209	210	CHAR

The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).

COBOL ALIAS : MSC
COMMON ALIAS : MSC
DB2 ALIAS : BENE_MDCR_STUS_CD
SAS ALIAS : MS_CD
STANDARD ALIAS : CWF_BENE_MDCR_STUS_CD
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :
CWF derives MSC from the following:
1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE
10	YES	N/A	NO	65 and over
11	YES	N/A	YES	65 and over
20	NO	YES	NO	under 65
21	NO	YES	YES	under 65
31	NO	NO	YES	any age

BIC

N/A

N/A

N/A

N/A

T.

COMMENTS :

Prior to Version H this field was named: BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE : CWF

CODE TABLE : BENE_MDCR_STUS_TB

54. Claim Patient 6 Position Surname

6	211	216	CHAR

The first 6 positions of the Medicare patient's surname (last name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT_SURNAME
DB2 ALIAS : PTNT_6_PSTN_SRNM
SAS ALIAS : SURNAME
STANDARD ALIAS : CLM_PTNT_6_PSTN_SRNM_NAME
TITLE ALIAS : PATIENT_SURNAME

LENGTH : 6

SOURCE : CWF

55. Claim Patient 1st Initial Given Name

1	217	217	CHAR

The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT_GIVEN_NAME
DB2 ALIAS : 1ST_INITL_GVN_NAME
SAS ALIAS : FRSTINIT
STANDARD ALIAS : CLM_PTNT_1ST_INITL_GVN_NAME
TITLE ALIAS : PATIENT_FIRST_INITIAL

LENGTH : 1

SOURCE : CWF

56. Claim Patient First Initial Middle Name

1	218	218	CHAR

The first initial of the Medicare patient's middle name as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record.

Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT_MIDDLE_NAME
DB2 ALIAS : 1ST_INITL_MDL_NAME
SAS ALIAS : MDL_INIT
STANDARD ALIAS : CLM_PTNT_1ST_INITL_MDL_NAME
TITLE ALIAS : PATIENT_MIDDLE_INITIAL

LENGTH : 1

SOURCE : CWF

57. Beneficiary CWF Location Code

1	219	219	CHAR

The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.

COMMON ALIAS : CWF_HOST
DB2 ALIAS : BENE_CWF_LOC_CD
SAS ALIAS : CWFLOCCD
STANDARD ALIAS : BENE_CWF_LOC_CD
TITLE ALIAS : CWF_HOST

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE_CWF_LOC_TB

58. Claim Principal Diagnosis Code

5	220	224	CHAR

The ICD-9-CM diagnosis code identifying the condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

DB2 ALIAS : PRNCPAL_DGNS_CD
SAS ALIAS : PDGNS_CD
STANDARD ALIAS : CLM_PRNCPAL_DGNS_CD
TITLE ALIAS : PRINCIPAL_DIAGNOSIS

LENGTH : 5

SOURCE : CWF

EDIT RULES :
ICD-9-CM

59. FILLER

1	225	225	CHAR

DB2 ALIAS : FILLER

LENGTH : 1

60. Claim Medicare Non Payment Reason Code

1	226	226	CHAR

The reason that no Medicare payment is made for

services on an institutional claim.

was

NOTE: Effective with Version I, this field put on all institutional claim types.

institutional

on

4/1/02,

NOTE1: This field was put on all claim types but data did not start coming in OP/HHA/Hospice until 4/1/02. Prior to data only came in Inpatient/SNF claims.

NOTE2: Effective 4/1/02, this field was also expanded to two bytes to accommodate new values.

The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

DB2 ALIAS : MDCR_NPMT_RSN_CD
SAS ALIAS : NOPAY_CD
STANDARD ALIAS : CLM_MDCR_NPMT_RSN_CD
TITLE ALIAS : NON_PAYMENT_REASON

LENGTH : 1

SOURCE : CWF

EDIT RULES :
OPTIONAL

CODE TABLE : CLM_MDCR_NPMT_RSN_TB

61. Claim Excepted/Nonexcepted Medical Treatment Code

1 227 227 CHAR

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is re- quired under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS : EXCPTD_NEXCPTD_CD
SAS ALIAS : TRTMT_CD
STANDARD ALIAS : CLM_EXCPTD_NEXCPTD_TRTMT_CD
TITLE ALIAS : EXCPTD_NEXCPTD_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_EXCPTD_NEXCPTD_TRTMT_TB

62. Claim Payment Amount

6 228 233 PACK

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some

may be pre-
the full
deductible exceeded
beneficiary is
stay and the
Medicare pays (most
who are paid a
charges are.)

paid based on
DRG patient
On the IP
DRG outlier
share (since
10/1/88), total
the payment
add-on amount.
(i.e., capital-
costs, kidney
beneficiary-paid
or any

services are paid
using the
and the PRICER
payment is
operating and
routine and
adjusted for wage,
transfers,
and high
adjustments could
certain pass-
education
payer reim-
scope of PPS.

services are paid
based on the
based on a
inpatient operating

situations, a negative claim payment amount
sent; e.g., (1) when a beneficiary is charged
deductible during a short stay and the
the amount Medicare pays; or (2) when a
charged a coinsurance amount during a long
coinsurance amount exceeds the amount
prevalent situation involves psych hospitals
daily per diem rate no matter what the

Under IP PPS, inpatient hospital services are
a predetermined rate per discharge, using the
classification system and the PRICER program.
PPS claim, the payment amount includes the
approved payment amount, disproportionate
5/1/86), indirect medical education (since
PPS capital (since 10/1/91). After 4/1/03,
amount could also include a "new technology"
It does NOT include the pass-thru amounts
related costs, direct medical education
acquisition costs, bad debts); or any
amounts (i.e., deductibles and coinsurance);
any other payer reimbursement.
Under IRFPPS, inpatient rehabilitation
based on a predetermined rate per discharge,
Case Mix Group (CMG) classification system
program. From the CMG on the IRF PPS claim,
based on a standard payment amount for
capital cost for that facility (including
ancillary services). The payment is
the % of low-income patients (LIP), locality,
interrupted stays, short stay cases, deaths,
cost outliers. Some or all of these
apply. The CMG payment does NOT include
through costs (i.e. bad debts, approved
activities); beneficiary-paid amounts, other
bursement,and other services outside of the

Under LTCH PPS, long term care hospital
based on a predetermined rate per discharge
DRG and the PRICER program. Payments are
single standard Federal rate for both
and capital-related costs (including routine

and ancillary
through costs
new technologies
the payment
interrupted stays,
living adjust-

beneficiaries using the
III. For the
calculate/return the rate
revenue center code =
count; and then
revenue center
payment amount.

payment
for each APC
claim payment.
payment and

classified into
Home Health
generated
(HHRG).

payment amount
60% (for first
the case mix
index adjusted.

of the amount
an adjustment
full. Although
the provider will
payment may

BBA encounter
not just

contain
special
payment system

services), but do NOT include certain pass-
(i.e. bad debts, direct medical education,
and blood clotting factors). Adjustments to
may occur due to short-stay outliers,
high cost outliers, wage index, and cost of
ments.
Under SNF PPS, SNFs will classify
patient classification system known as RUGS
SNF PPS claim, the SNF PRICER will
for each revenue center line item with
'0022'; multiply the rate times the units
sum the amount payable for all lines with
code '0022' to determine the total claim

Under Outpatient PPS, the national ambulatory
classification (APC) rate that is calculated
group is the basis for determining the total
The payment amount also includes the outlier
interest.
Under Home Health PPS, beneficiaries will be
an appropriate case mix category known as the
Resource Group. A HIPPS code is then
corresponding to the case mix category

For the RAP, the PRICER will determine the
appropriate to the HIPPS code by computing
episode) or 50% (for subsequent episodes) of
episode payment. The payment is then wage

For the final claim, PRICER calculates 100%
due, because the final claim is processed as
to the RAP, reversing the RAP payment in
final claim will show 100% payment amount,
actually receive the 40% or 50% payment. The
also include outlier payments.
Exceptions: For claims involving demos and
data, the amount reported in this field may
represent the actual provider payment.
For demo Ids '01','02','03','04' -- claims
amount paid to the provider, except that
'differentials' paid outside the normal
are not included.

'claims'
FFS,

actual
negotiated
services.
Part A
'Y4'. The
claims
been no

'claims' contain
instead of

was S9(7)V99. Also,
this field as a line
is a claim level
item field has been

and

Medicare
consideration
erroneous
30% of

over

63. NCH Primary Payer Claim Paid Amount
6 234 239 PACK

Medicare
Medicare, that the

For demo Ids '05','15' -- encounter data
contain amount Medicare would have paid under
instead of the actual payment to the MCO.
For demo Ids '06','07','08' -- claims contain
provider payment but represent a special
bundled payment for both Part A and Part B
To identify what the conventional provider
payment would have been, check value code =
related noninstitutional (physician/supplier)
contain what would have been paid had there
demo.
For BBA encounter data (non-demo) --
amount Medicare would have paid under FFS,
the actual payment to the BBA plan.

COMMON ALIAS : REIMBURSEMENT
DB2 ALIAS : CLM_PMT_AMT
SAS ALIAS : PMT_AMT
STANDARD ALIAS : CLM_PMT_AMT
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H the size of this field
the noninstitutional claim records carried
item. Effective with Version H, this element
field across all claim types (and the line
renamed.)

SOURCE : CWF

LIMITATIONS :
Prior to 4/6/93, on inpatient, outpatient,
physician/supplier claims containing a
CLM_DISP_CD of '02', the amount shown as the
reimbursement does not take into
any CWF automatic adjustments (involving
deductibles in most cases). In as many as
the claims (30% IP, 15% OP, 5% PART B), the
reimbursement reported on the claims may be
or under the actual Medicare payment amount.

REFER TO :
PMT_AMT_EXCEDG_CHRG_AMT_LIM

EDIT RULES :
$$$$$$$$$CC

The amount of a payment made on behalf of a
beneficiary by a primary payer other than

charges on an

provider is applying to covered Medicare

institutional, carrier, or DMERC claim.

DB2 ALIAS : PRMRY_PYR_PD_AMT
STANDARD ALIAS : NCH_PRMRY_PYR_CLM_PD_AMT
TITLE ALIAS : PRIMARY_PAYER_AMOUNT

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H this field was named: BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99.

SOURCE : NCH

EDIT RULES :
$$$$$$$$$CC

64. NCH Primary Payer Code

1 240 240 CHAR

specifying a federal

primary

Medicare beneficiary's

The code, on an institutional claim,

non-Medicare program or other source that has

responsibility for the payment of the

health insurance bills.

DB2 ALIAS : NCH_PRMRY_PYR_CD
SAS ALIAS : PRPAY_CD
STANDARD ALIAS : NCH_PRMRY_PYR_CD
TITLE ALIAS : PRIMARY_PAYER_CD

LENGTH : 1

DERIVATIONS :
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE CLM_VAL_CD = '12'

SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE CLM_VAL_CD = '13'

SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14'

SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15'

SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT not equal to zeroes)

SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43'

SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM_VAL_CD = '41'

SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE CLM_VAL_CD = '42'

SET NCH_PRMRY_PYR_CD TO 'L' (or prior to

4/97

set code to 'J') WHERE THE CLM_VAL_CD =

'47'

COMMENTS :
Prior to Version H this field was named: BENE PRMRY PYR CD.

SOURCE : NCH

CODE TABLE : BENE_PRMRY_PYR_TB

65. FI Requested Claim Cancel Reason Code

1	241	241	CHAR

The reason that an intermediary requested cancelling a previously submitted institutional claim.

DB2 ALIAS : RQST_CNCL_RSN_CD
SAS ALIAS : CANCELCD
STANDARD ALIAS : FI_RQST_CLM_CNCL_RSN_CD
TITLE ALIAS : CANCEL_CD

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: INTRMDRY_RQST_CLM_CNCL_RSN_CD.

SOURCE : CWF

CODE TABLE : FI_RQST_CLM_CNCL_RSN_TB

66. FI Claim Action Code

1	242	242	CHAR

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

DB2 ALIAS : FI_CLM_ACTN_CD
SAS ALIAS : ACTIONCD
STANDARD ALIAS : FI_CLM_ACTN_CD
TITLE ALIAS : ACTION_CD

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: INTRMDRY_CLM_ACTN_CD.

SOURCE : CWF

CODE TABLE : FI_CLM_ACTN_TB

67. FI Claim Process Date

8	243	250	NUM

The date the fiscal intermediary completes processing and releases the institutional claim to the CWF host.

DB2 ALIAS : FI_CLM_PROC_DT
SAS ALIAS : APRVL_DT
STANDARD ALIAS : FI_CLM_PROC_DT
TITLE ALIAS : FI_PROCESS_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

68. NCH Provider State Code

2	251	252	CHAR

Effective with Version H, the two position SSA state code where provider facility is located.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH_PRVDR_STATE_CD
SAS ALIAS : PRSTATE
STANDARD ALIAS : NCH_PRVDR_STATE_CD
TITLE ALIAS : PROVIDER_STATE_CD

LENGTH : 2

DERIVATIONS :
DERIVED FROM:
NCH PRVDR_NUM

DERIVATION RULES:

```
SET NCH_PRVDR_STATE_CD TO
    PRVDR_NUM POS1-2.
FOR PRVDR_NUM POS1-2 EQUAL '55' OR '75'
  SET NCH_PRVDR_STATE_CD TO '05'.
FOR PRVDR_NUM POS1-2 EQUAL '67' OR '74'
  SET NCH_PRVDR_STATE_CD TO '45'.
FOR PRVDR_NUM POS1-2 EQUAL '68' OR '69'
  SET NCH_PRVDR_STATE_CD TO '10'.
FOR PRVDR_NUM POS1-2 EQUAL '78'
  SET NCH_PRVDR_STATE_CD TO '14'
FOR PRVDR_NUM POS1-2 EQUAL TO '76'
  SET NCH_PRVDR_STATE_CD TO '16'
FOR PRVDR_NUM POS1-2 EQUAL '70'
  SET NCH_PRVDR_STATE_CD TO '17'
FOR PRVDR_NUM POS1-2 EQUAL '71'
  SET NCH_PRVDR_STATE_CD TO '19'
FOR PRVDR_NUMBER POS1-2 EQUAL '77'
  SET NCH_PRVDR_STATE_CD TO '24'
FOR PRVDR_NUM POS1-2 EQUAL TO '72'
  SET NCH_PRVDR_STATE_CD TO '36'
FOR PRVDR_NUM POS1-2 EQUAL TO '73'
  SET NCH_PRVDR_STATE_CD TO '39'
```

SOURCE : NCH

CODE TABLE : GEO_SSA_STATE_TB

69. Organization NPI Number 10 253 262 CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on 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 (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implelmentation, the standard system main-tainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : ORG_NPI_NUM
SAS ALIAS : ORGNPINM
STANDARD ALIAS : ORG_NPI_NUM
TITLE ALIAS : ORG_NPI

LENGTH : 10

SOURCE : CWF

70. Attending Physician ID Group
24 263 286 GRP

Name and identification numbers associated with the primary care physician.

71. Claim Attending Physician UPIN Number
6 263 268 CHAR

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

COMMON ALIAS : ATTENDING_PHYSICIAN_UPIN
DB2 ALIAS : ATNDG_UPIN_NUM
SAS ALIAS : AT_UPIN
STANDARD ALIAS : CLM_ATNDG_PHYSN_UPIN_NUM
TITLE ALIAS : ATTENDING_PHYSICIAN

LENGTH : 6

COMMENTS :
Prior to Version H this field was named: CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

SOURCE : CWF

72. Claim Attending Physician NPI Number
10 269 278 CHAR

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

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on 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 (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW

physicians (Part B and Outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

COMMON ALIAS : ATTENDING_PHYSICIAN_NPI
DB2 ALIAS : ATNDG_NPI_NUM
SAS ALIAS : AT_NPI
STANDARD ALIAS : CLM_ATNDG_PHYSN_NPI_NUM
TITLE ALIAS : ATNDG_NPI

LENGTH : 10

SOURCE : CWF

73. Claim Attending Physician Surname

6	279	284	CHAR

Effective with Version H, the last name of the attending physician (used for internal editing purpose in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG_SRNM
SAS ALIAS : AT_SRNM
STANDARD ALIAS : CLM_ATNDG_PHYSN_SRNM_NAME
TITLE ALIAS : ANDG_PHYSN_SURNAME

LENGTH : 6

SOURCE : CWF

74. Claim Attending Physician Given Name

1	285	285	CHAR

Effective with Version H, the first name of the attending physician (used for internal editing purposes in CMS' CWFMQA system).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG_GVN_NAME
SAS ALIAS : AT_GVNNM
STANDARD ALIAS : CLM_ATNDG_PHYSN_GVN_NAME
TITLE ALIAS : ATNDG_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

75. Claim Attending Physician Middle Initial Name

1	286	286	CHAR

Effective with Version H, the middle initial of the attending physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG_MI_NAME
SAS ALIAS : AT_MDL
STANDARD ALIAS : CLM_ATNDG_PHYSN_MDL_INITL_NAME
TITLE ALIAS : ATNDG PHYSN MI

LENGTH : 1

SOURCE : CWF

76. Operating Physician ID Group
24 287 310 GRP

Name and identification numbers associated with the physician who performed the principal procedure.

STANDARD ALIAS : OPRTG_PHYSN_ID_GRP

77. Claim Operating Physician UPIN Number
6 287 292 CHAR

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

DB2 ALIAS : OPRTG_UPIN
SAS ALIAS : OP_UPIN
STANDARD ALIAS : CLM_OPRTG_PHYSN_UPIN_NUM
TITLE ALIAS : OPRTG_UPIN

LENGTH : 6

COMMENTS :
Prior to Version H this field was named: CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position physician surname.

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE : CWF

78. Claim Operating Physician NPI Number
10 293 302 CHAR

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

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on 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 (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy number and new NPI) must be available in the NCH. After the

5/07

NPI implementation, the standard system

maint-

tainers will add the legacy number to the

claim

when its adjudicated. We will continue to receive the OSCAR provider number and any

currently

issued UPINs. Effective May 2007, no NEW

UPINs

(legacy numbers) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : OPRTG_NPI
SAS ALIAS : OP_NPI
STANDARD ALIAS : CLM_OPRTG_PHYSN_NPI_NUM
TITLE ALIAS : OPRTG_NPI

LENGTH : 10

SOURCE : CWF

79. Claim Operating Physician Surname

6	303	308	CHAR

Effective with Version H, the last name of

the

operating physician (used for internal

editing

purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process

date

10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will

contain

spaces in this field.

DB2 ALIAS : OPRTG_SRNM
SAS ALIAS : OP_SRNM
STANDARD ALIAS : CLM_OPRTG_PHYSN_SRNM_NAME
TITLE ALIAS : OPRTG_PHYSN_SURNAME

LENGTH : 6

SOURCE : CWF

80. Claim Operating Physician Given Name

1	309	309	CHAR

Effective with Version H, the first name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will

contain

spaces in this field.

DB2 ALIAS : OPRTG_GVN_NAME
SAS ALIAS : OP_GVN
STANDARD ALIAS : CLM_OPRTG_PHYSN_GVN_NAME
TITLE ALIAS : OPRTG_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

81. Claim Operating Physician Middle Initial Name

1	310	310	CHAR

Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will

contain

spaces in this field.

DB2 ALIAS : OPRTG_MI_NAME
SAS ALIAS : OP_MDL
STANDARD ALIAS :
CLM_OPRTG_PHYSN_MDL_INITL_NAME

TITLE ALIAS : OPRTG_PHYSN_MI

LENGTH : 1

SOURCE : CWF

82. Other Physician ID Group
24 311 334 GRP

Name and identification numbers associated
with the other

physician.

STANDARD ALIAS : OTHR_PHYSN_ID_GRP

83. Claim Other Physician UPIN Number
6 311 316 CHAR

On an institutional claim, the unique
physician

identification number (UPIN) of the other physician associated with the institutional claim.

DB2 ALIAS : OTHR_UPIN
SAS ALIAS : OT_UPIN
STANDARD ALIAS : CLM_OTHR_PHYSN_UPIN_NUM
TITLE ALIAS : OTH_PHYSN_UPIN

LENGTH : 6

COMMENTS :
Prior to Version H this field was named: CLM_OTHR_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname).

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this
field

was populated with data. HHA and Hospice
claims

processed prior to 10/3/97 will contain
spaces.

SOURCE : CWF

84. Claim Other Physician NPI Number
10 317 326 CHAR

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

NOTE: Effective May 2007, the NPI will be-come the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on 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 (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system main-tainers will add the legacy number to the

claim

when it is adjudicated. We will continue to receive the OSCAR provider number and any

currently

issued UPINs. Effective May 2007, no NEW

UPINs

(legacy number) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the

NCH

for those physicians.

DB2 ALIAS : OTHR_NPI
SAS ALIAS : OT_NPI
STANDARD ALIAS : CLM_OTHR_PHYSN_NPI_NUM

LENGTH : 10

SOURCE : CWF

85. Claim Other Physician Surname
6 327 332 CHAR

Effective with Version H, the last name of

the

other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process

date

10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will

contain

spaces in this field.

DB2 ALIAS : OTHR_SRNM
SAS ALIAS : OT_SRNM
STANDARD ALIAS : CLM_OTHR_PHYSN_SRNM_NAME
TITLE ALIAS : OTH_PHYSN_SURNAME

LENGTH : 6

SOURCE : CWF

86. Claim Other Physician Given Name
1 333 333 CHAR

Effective with Version H, the first name of

the

other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will

contain

spaces in this field.

DB2 ALIAS : OTHR_GVN_NAME
SAS ALIAS : OT_GVN
STANDARD ALIAS : CLM_OTHR_PHYSN_GVN_NAME
TITLE ALIAS : OTH_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

87. Claim Other Physician Middle Initial Name
1 334 334 CHAR

Effective with Version H, the middle initial

of

the other physician (used for internal

editing

purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will

contain

spaces in this field.

DB2 ALIAS : OTHR_MI_NAME
SAS ALIAS : OT_MDL
STANDARD ALIAS :

CLM_OTHR_PHYSN_MDL_INITL_NAME

TITLE ALIAS : OTH_PHYSN_MI

LENGTH : 1

SOURCE : CWF

88. Medicaid Provider Identification Number

13	335	347	CHAR

A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and to maintain claims history on individual providers for surveillance and utilization review.

DB2 ALIAS : MDCD_PRVDR_NUM
SAS ALIAS : MDCD_PRV
STANDARD ALIAS : MDCD_PRVDR_IDENT_NUM
TITLE ALIAS : MEDICAID_PROVIDER

LENGTH : 13

COMMENTS :
Prior to Version H the field size was X(12).

SOURCE : CWF

89. Claim Medicaid Information Code

4	348	351	CHAR

Effective with Version G, code identifying information supplied by the contractor to Medicaid Medicaid.

DB2 ALIAS : CLM_MDCD_INFO_CD
SAS ALIAS : MDCDINFO
STANDARD ALIAS : CLM_MDCD_INFO_CD
TITLE ALIAS : MEDICAID_INFO

LENGTH : 4

SOURCE : CWF

90. Claim MCO Paid Switch

1	352	352	CHAR

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

COBOL ALIAS : MCO_PD_IND
DB2 ALIAS : CLM_MCO_PD_SW
SAS ALIAS : MCOPDSW
STANDARD ALIAS : CLM_MCO_PD_SW
TITLE ALIAS : MCO_PAID_SW

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: CLM_GHO_PD_SW.

SOURCE : CWF

LIMITATIONS :

REFER TO :
MCO_PD_SW_LIM

CODE TABLE : CLM_MCO_PD_TB

91. Claim Treatment Authorization Number

18	353	370	CHAR

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

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

NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code.

COMMON ALIAS : TAN
DB2 ALIAS : TRTMT_AUTHRZTN_NUM
SAS ALIAS : AUTHRZTN
STANDARD ALIAS : CLM_TRTMT_AUTHRZTN_NUM
TITLE ALIAS : TREATMENT_AUTHORIZATION

LENGTH : 18

SOURCE : CWF

92. Patient Control Number

20	371	390	CHAR

The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payments.

DB2 ALIAS : PTNT_CNTL_NUM
SAS ALIAS : PTNTCNTL
STANDARD ALIAS : PTNT_CNTL_NUM
TITLE ALIAS : PATIENT_CONTROL_NUM

LENGTH : 20

SOURCE : CWF

93. Claim Medical Record Number

17	391	407	CHAR

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

DB2 ALIAS : CLM_MDCL_REC_NUM
SAS ALIAS : MDCL_REC
STANDARD ALIAS : CLM_MDCL_REC_NUM
TITLE ALIAS : MEDICAL_RECORD_NUM

LENGTH : 17

SOURCE : CWF

94. Claim PRO Control Number

12	408	419	CHAR

Effective with Version G, the unique identifier assigned by the Peer Review Organization

(PRO)

for control purposes.

DB2 ALIAS : CLM_PRO_CNTL_NUM
SAS ALIAS : PRO_CNTL
STANDARD ALIAS : CLM_PRO_CNTL_NUM
TITLE ALIAS : PRO_CONTROL_NUM

LENGTH : 12

SOURCE : CWF

95. Claim PRO Process Date

8	420	427	NUM

Effective with Version H, the date the claim was used in the PRO review process.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CLM_PRO_PROC_DT
SAS ALIAS : PRO_DT
STANDARD ALIAS : CLM_PRO_PROC_DT
TITLE ALIAS : PRO_PROC_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

96. Patient Discharge Status Code

2	428	429	CHAR

The code used to identify the status of the patient as of the CLM_THRU_DT.

DB2 ALIAS : PTNT_DSCHRG_STUS
SAS ALIAS : STUS_CD
STANDARD ALIAS : PTNT_DSCHRG_STUS_CD
TITLE ALIAS : PTNT_DSCHRG_STUS_CD

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: CLM_STUS_CD.

SOURCE : CWF

CODE TABLE : PTNT_DSCHRG_STUS_TB

97. Claim Diagnosis E Code

5	430	434	CHAR

Effective with Version H, the ICD-9-CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly this field is also stored as the last occurrence of the diagnosis trailer.

NOTE: During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history.

DB2 ALIAS : CLM_DGNS_E_CD
SAS ALIAS : DGNS_E
STANDARD ALIAS : CLM_DGNS_E_CD
TITLE ALIAS : DGNS_E_CD

LENGTH : 5

SOURCE : CWF

98. FILLER — 1 | 435 | 435 | CHAR

DB2 ALIAS : FILLER

LENGTH : 1

99. Claim PPS Indicator Code — 1 | 436 | 436 | CHAR

Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

COBOL ALIAS : PPS_IND
DB2 ALIAS : CLM_PPS_IND_CD
SAS ALIAS : PPS_IND
STANDARD ALIAS : CLM_PPS_IND_CD
TITLE ALIAS : PPS_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_PPS_IND_TB

100. Claim Total Charge Amount — 6 | 437 | 442 | PACK

Effective with Version G, the total charges for all services included on the institutional claim.

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

DB2 ALIAS : CLM_TOT_CHRG_AMT
SAS ALIAS : TOT_CHRG
STANDARD ALIAS : CLM_TOT_CHRG_AMT
TITLE ALIAS : CLAIM_TOTAL_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H the size of this field was S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :
TOT_CHRG_AMT_LIM

101. Claim Pricer Return Code — 2 | 443 | 444 | CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify various PPS payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by a PRICER

(Inpatient,
(IRF),

of

in
from

NCH/NMUD
444

Outpatient, SNF, Inpatient Rehab Facility
Home Health and Hospice).
The payment return code identifies the type
payment calculated by the PRICER software.
The error return code identifies a condition
a claim that prevents the PRICER software
calculating a correct payment.
NOTE: Prior to 10/2005 (implementation of
CR#2), this data was stored in positions 443-
(FILLER) on all institutional claim types.

DB2 ALIAS : CLM_PRCR_RTRN_CD
SAS ALIAS : PRCRRTRN
STANDARD ALIAS : CLM_PRCR_RTRN_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_PRCR_RTRN_TB

102. Claim Business Segment Identifier Code
4 445 448 CHAR

of NCH/NMUD
byte juris-
state/territory
byte
FFS
DMERC).

segment
work-
implemen-
MMA.

Effective 10/1/2005 with the implementation
CR#2, the identifier that captures the 2-
diction code (represents the USPS
abbreviation (i.e. NY = New York) and the 2-
modifier that identifies the type of Medicare
contract (intermediary, RHHI, carrier or
This 4-byte identifier along with the 5-byte
FI/Carrier number comprises the Contractor
Workload Identifier number. The business
identifier (BSI) is intended to help sort
loads that may be redistributed with the
tation of contracting reform as required by

DB2 ALIAS : BUSNS_SGMT_ID_CD
SAS ALIAS : SGMT_ID
STANDARD ALIAS : CLM_BUSNS_SGMT_ID_CD

LENGTH : 4

SOURCE : CWF

103. FILLER
44 449 492 CHAR

DB2 ALIAS : FILLER

LENGTH : 44

104. HHA NCH Edit Code Count
2 493 494 NUM

The count of the number of edit codes
annotated to the HHA claim during the
HCFA's CWFMQA process. The purpose of
this count is to indicate how many claim
edit trailers are present.

DB2 ALIAS : HHA EDIT CD CNT

SAS ALIAS : HHEDCNT
STANDARD ALIAS : HHA_NCH_EDIT_CD_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_EDIT_CD_CNT.

SOURCE : NCH

105. HHA NCH Patch Code Count

2 495 496 NUM

Effective with Version H, the count of the number of HCFA patch codes annotated to the home health claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: Effective with Version 'I' the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99.

DB2 ALIAS : HHA_PATCH_CD_CNT
SAS ALIAS : HHPATCNT
STANDARD ALIAS : HHA_NCH_PATCH_CD_I_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

106. HHA MCO Period Count

1 497 497 NUM

Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an home health agency claim. The purpose of this count is to indicate how many MCO period trailers are present.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : HHA_MCO_PRD_CNT
SAS ALIAS : HHMCOCNT
STANDARD ALIAS : HHA_MCO_PRD_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 2

107. HHA Claim Health PlanID Count

1 498 498 NUM

A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the HHA claim. The purpose of this count is to indicate how many Health PlanID trailers are present. NOTE: Prior to Version 'I' this field was named: HHA_CLM_PAYERID_CNT.

DB2 ALIAS : HHA_PLANID_CNT
SAS ALIAS : HHPLANNT
STANDARD ALIAS : HHA CLM HLTH PLANID CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 3

108. HHA Claim Demonstration ID Count
1 499 499 NUM

Effective with Version H, the count of the number of claim demonstration IDs reported on an HHA claim. The purpose of this count is to indicate how many claim demonstration trailers are present.

NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

DB2 ALIAS : HHA_DEMO_ID_CNT
SAS ALIAS : HHDEMCNT
STANDARD ALIAS : HHA_CLM_DEMO_ID_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 5

109. HHA Claim Diagnosis Code Count
2 500 501 NUM

Effective with Version H, the count of the number of claim demonstration IDs reported on an HHA claim. The purpose of this count is to indicate how many claim demonstration trailers are present.

NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

DB2 ALIAS : HHA_DGNS_CD_CNT
SAS ALIAS : HHDGNCNT
STANDARD ALIAS : HHA_CLM_DGNS_CD_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_OTHR_DGNS_CD_CNT and the principal was not included in the count.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 10

110. FILLER
2 502 503 CHAR

DB2 ALIAS : FILLER

LENGTH : 2

111. HHA Claim Related Condition Code Count
2 504 505 NUM

The count of the number of condition codes reported on an HHA claim. The purpose of this count is to indicate how many condition code trailers are present.

DB2 ALIAS : HHA_COND_CD_CNT
SAS ALIAS : HHCONCNT
STANDARD ALIAS : HHA_CLM_RLT_COND_CD_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_RLT_COND_CD_CNT.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 30

112. HHA Claim Related Occurrence Code Count

	2	506	507

NUM

The count of the number of occurrence codes reported on an HHA claim. The purpose of this count is to indicate how many occurrence code trailers are present.

DB2 ALIAS : HHA_RLT_OCRNC_CNT
SAS ALIAS : HHOCRCNT
STANDARD ALIAS : HHA_CLM_RLT_OCRNC_CD_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_RLT_OCRNC_CD_CNT.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 30

113. HHA Claim Occurrence Span Code Count

	2	508	509

NUM

The count of the number of occurrence span codes reported on an HHA claim. The purpose of the count is to indicate how many span code trailers are present.

DB2 ALIAS : HHA_OCRNC_SPAN_CNT
SAS ALIAS : HHSPNCNT
STANDARD ALIAS : HHA_CLM_OCRNC_SPAN_CD_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_OCRNC_SPAN_CD_CNT.

SOURCE : NCH

114. HHA Claim Value Code Count

	2	510	511

NUM

The count of the number of value codes reported on an HHA claim. The purpose of the count is to indicate how many value code trailers are present.

DB2 ALIAS : HHA_CLM_VAL_CD_CNT
SAS ALIAS : HHVALCNT
STANDARD ALIAS : HHA_CLM_VAL_CD_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_VAL_CD_CNT.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 36

115. HHA Revenue Center Code Count

2	512	513	NUM

The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate how many revenue center trailers are present.

DB2 ALIAS : HHA_REV_CNTR_CNT
SAS ALIAS : HHREVCNT
STANDARD ALIAS : HHA_REV_CNTR_CD_I_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_REV_CNTR_CD_CNT.

NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to

Version 'I' the number of occurrences was 58.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 45

116. FILLER

4	514	517	CHAR

DB2 ALIAS : FILLER

LENGTH : 4

117. FI HHA Claim Specific Group

52	518	569	GRP

Data pertaining only to fiscal intermediary HHA claims.

118. Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code

1	518	518	CHAR

Effective with Version I, the code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will

be reimbursed based on a national standardized

per visit rate instead of HHRGs.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces.

DB2 ALIAS : HHA_LUPA_IND_CD
SAS ALIAS : LUPAIND
STANDARD ALIAS : CLM_HHA_LUPA_IND_CD
TITLE ALIAS : HHA_TOT_VISITS

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :
HHA_PPS_LUPA_IND_CD_LIM

CODE TABLE : CLM_HHA_LUPA_IND_TB

119. Claim HHA Referral Code

1	519	519	CHAR

Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for Home Health services.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces in this field.

DB2 ALIAS : CLM_HHA_RFRL_CD
SAS ALIAS : HHA_RFRL
STANDARD ALIAS : CLM_HHA_RFRL_CD
TITLE ALIAS : HHA_REFERRAL_CODE

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :
HHA_RFRL_CD_LIM

CODE TABLE : CLM_HHA_RFRL_TB

120. Claim HHA Total Visit Count
2 520 521 PACK

number

field
(back to
rule
042X,
Value
revenue

received
will be
15
code
This field
derive
revise their
ADDING
VISIT

Effective with Version H, the count of the of HHA visits as derived by CWF.

NOTE1: During the Version H conversion this was populated with data throughout history service year 1991) using the CWF derivation (units associated with revenue center codes 043X, 044X, 055X, 056X, 057X, 058X and 059X. '999' will be displayed if the sum of the center unit count equals or exceeds '999'.

NOTE2: Effective 7/1/99, all HHA claims with service from dates 7/1/99 and after processed as if the units field contains the minute interval count; and each visit revenue line item will be counted as ONE visit.
is calculated correctly; but those users who the count themselves they will have to routine. NO LONGER IS THE COUNT DERIVED BY UP THE UNITS FIELDS ASSOCIATED WITH THE HHA REVENUE CODES.

DB2 ALIAS : HHA_TOT_VISIT_CNT
SAS ALIAS : VISITCNT
STANDARD ALIAS : CLM_HHA_TOT_VISIT_CNT
TITLE ALIAS : HHA_TOT_VISITS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

LIMITATIONS :

REFER TO :
HHA_TOT_VISIT_CNT_LIM

121. NCH Qualified Stay From Date

8 522 529 NUM

of
internal
claims, the
for
For
stay
a row
least
admission

field
(back to

Effective with Version H, the beginning date the beneficiary's qualifying stay (used for CWFMQA editing purposes). For inpatient date relates to the PPS portion of the inlier which there is no utilization to benefits. SNF claims, the date relates to a qualifying from a hospital that is at least two days in if the source of admission is an 'A', or at three days in a row if the source of is other than 'A'.

NOTE: During the Version H conversion this was populated with data throughout history service year 1991).

DB2 ALIAS : QLFY_STAY_FROM_DT
SAS ALIAS : QLFYFROM
STANDARD ALIAS : NCH_QLFY_STAY_FROM_DT
TITLE ALIAS : QLFYG_STAY_FROM_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_FROM_DT

DERIVATION RULES:
Based on the presence of occurrence code 70 move the related occurrence from date to NCH_QLFY_STAY_FROM_DT.

SOURCE : NCH QA Process

EDIT RULES :
YYYYMMDD

122. NCH Qualify Stay Through Date

8 530 537 NUM

internal
claims, the
for
For
stay
a row
least
admission

field
(back to

Effective with Version H, the ending date of the beneficiary's qualifying stay (used for CWFMQA editing purposes.) For inpatient date relates to the PPS portion of the inlier which there is no utilization to benefits. SNF claims, the date relates to a qualifying from a hospital that is at least two days in if the source of admission is an 'A', or at three days in a row if the source of is other than 'A'.

NOTE: During the Version H, conversion this was populated with data throughout history service year 1991).

DB2 ALIAS : QLFY_STAY_THRU_DT
SAS ALIAS : QLFYTHRU
STANDARD ALIAS : NCH QLFY STAY THRU DT

TITLE ALIAS : QLFYG_STAY_THRU_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_THRU_DT

DERIVATION RULES:
Based on the presence of occurrence code 70 move the related occurrence thru date to NCH_QLFY_STAY_THRU_DT.

SOURCE : NCH QA Process

EDIT RULES :
YYYYMMDD

123. NCH Beneficiary Discharge Date

8	538	545	NUM

Effective with Version H, on an inpatient and HHA claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.)

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991.)

DB2 ALIAS : NCH_BENE_DSCHRG_DT
SAS ALIAS : DSCHRGDT
STANDARD ALIAS : NCH_BENE_DSCHRG_DT
TITLE ALIAS : DISCHARGE_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

DERIVATION RULES:
Based on the presence of patient discharge status the claim code not equal to 30 (still patient), move thru date to the NCH_BENE_DSCHRG_DT.

SOURCE : NCH QA Process

EDIT RULES :
YYYYMMDD

124. Claim HHA Care Start Date

8	546	553	NUM

Effective with Version H, the date care started for the HHA services reported on the institutional claim with a from date greater than 3/31/98. The Balanced Budget Act (BBA) required that this field be present on all HHA claims.

NOTE1: Beginning with NCH weekly process date 4/3/98, this field was populated with data. Claims processed prior to 4/3/98 will contain zeroes in this field.

NOTE2: Effective with Version 'I', the start of care date will be moved from the 1st eight positions of the Claim Treatment Authorization

Number. Prior to Version 'I' this date was moved from Occurrence Code 27 date field.

DB2 ALIAS : HHA_CARE_STRT_DT
SAS ALIAS : HHSTRTDT
STANDARD ALIAS : CLM_HHA_CARE_STRT_DT
TITLE ALIAS : HHA_CARE_START_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

125. FILLER
16 554 569 CHAR

DB2 ALIAS : FILLER

LENGTH : 16

126. FI HHA Claim Variable Group
VAR 570 12263 GRP

Variable portion of the fiscal intermediary HHA claim record for version I of the NCH.

127. NCH Edit Group
5 570 574 GRP

The number of claim edit trailers is determined by the claim edit code count.

STANDARD ALIAS : NCH_EDIT_GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : HHA_NCH_EDIT_CD_CNT

128. NCH Edit Trailer Indicator Code
1 570 570 CHAR

Effective with Version H, the code indicating the presence of an NCH edit trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : EDIT_TRLR_IND_CD
SAS ALIAS : EDITIND
STANDARD ALIAS : NCH_EDIT_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_EDIT_TRLR_IND_TB

129. NCH Edit Code
4 571 574 CHAR

The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.

COMMON ALIAS : QA_ERROR_CODE
DB2 ALIAS : NCH_EDIT_CD
SAS ALIAS : EDIT_CD
STANDARD ALIAS : NCH_EDIT_CD
TITLE ALIAS : QA ERROR CD

LENGTH : 4

SOURCE : NCH QA EDIT PROCESS

CODE TABLE : NCH_EDIT_TB

130. NCH Patch Group

11 1 11 GRP

STANDARD ALIAS : NCH_PATCH_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HHA_NCH_PATCH_CD_I_CNT

131. NCH Patch Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of an NCH patch trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : PATCH_TRLR_IND_CD
SAS ALIAS : PATCHIND
STANDARD ALIAS : NCH_PATCH_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_PATCH_TRLR_IND_TB

132. NCH Patch Code

2 2 3 CHAR

Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.

NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.

DB2 ALIAS : NCH_PATCH_CD
SAS ALIAS : PATCHCD
STANDARD ALIAS : NCH_PATCH_CD
TITLE ALIAS : NCH_PATCH

LENGTH : 2

SOURCE : NCH

CODE TABLE : NCH_PATCH_TB

133. NCH Patch Applied Date

8 4 11 NUM

Effective with Version H, the date the NCH patch was applied to the claim.

DB2 ALIAS : NCH_PATCH_APPLY_DT
SAS ALIAS : PATCHDT
STANDARD ALIAS : NCH_PATCH_APPLY_DT
TITLE ALIAS : NCH_PATCH_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :

YYYYMMDD

134. MCO Period Group

37 1 37 GRP

The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.

STANDARD ALIAS : MCO_PRD_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : HHA_MCO_PRD_CNT

135. NCH MCO Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

COBOL ALIAS : MCO_IND
DB2 ALIAS : MCO_TRLR_IND_CD
SAS ALIAS : MCOIND
STANDARD ALIAS : NCH_MCO_TRLR_IND_CD
TITLE ALIAS : MCO_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_MCO_TRLR_IND_TB

136. MCO Contract Number

5 2 6 CHAR

Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO_CNTRCT_NUM
SAS ALIAS : MCONUM
STANDARD ALIAS : MCO_CNTRCT_NUM
TITLE ALIAS : MCO_NUM

LENGTH : 5

SOURCE : CWF

137. MCO Option Code

1 7 7 CHAR

Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will

contain

spaces in this field.

DB2 ALIAS : MCO_OPTN_CD
SAS ALIAS : MCOOPTN
STANDARD ALIAS : MCO_OPTN_CD
TITLE ALIAS : MCO_OPTION_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : MCO_OPTN_TB

138. MCO Period Effective Date

8	8	15	NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will
contain

zeroes in this field.

DB2 ALIAS : MCO_PRD_EFCTV_DT
SAS ALIAS : MCOEFFDT
STANDARD ALIAS : MCO_PRD_EFCTV_DT
TITLE ALIAS : MCO_PERIOD_EFF_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

139. MCO Period Termination Date

8	16	23	NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will
contain

zeroes in this field.

DB2 ALIAS : MCO_PRD_TRMNTN_DT
SAS ALIAS : MCOTRMDT
STANDARD ALIAS : MCO_PRD_TRMNTN_DT
TITLE ALIAS : MCO_PERIOD_TERM_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

140. MCO Health PLANID Number

14	24	37	CHAR

A placeholder field (effective with Version
H)

for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior
to

Version 'I' this field was named: MCO_PAYERID_NUM.

DB2 ALIAS : MCO_PLANID_NUM
SAS ALIAS : MCOPLNID
STANDARD ALIAS : MCO_HLTH_PLANID_NUM
TITLE ALIAS : MCO_PLANID

LENGTH : 14

COMMENTS :
Prior to Version I this field was named: MCO_PAYERID_NUM.

SOURCE : CWF

141. Claim Health PlanID Group

16 1 16 GRP

The number of Health PlanID data trailers is determined

by the claim Health PlanID trailer count.

Prior to Version 'I' this field was named: CLM_PAYERID_GRP.

STANDARD ALIAS : CLM_HLTH_PLANID_GRP

OCCURS MIN: 0 OCCURS MAX: 3

DEPENDING ON : HHA_CLM_HLTH_PLANID_CNT

142. NCH Health PlanID Trailer Indicator Code

1 1 1 CHAR

A placeholder field (effective with Version H)

for storing the code that indicates the presence

of a Health PlanID trailer. NOTE: Prior to Version 'I' this field was named: NCH_PAYERID_TRLR_IND_CD.

DB2 ALIAS : NCH_HLTH_PLANID_TR
SAS ALIAS : PLANIDIN
STANDARD ALIAS : NCH_HLTH_PLANID_TRLR_IND_CD

LENGTH : 1

COMMENTS :
Prior to Version I this field was named: NCH_PAYERID_TRLR_IND_CD.

SOURCE : NCH

CODE TABLE : NCH_HLTH_PLANID_TRLR_IND_TB

143. Claim Health PlanID Code

1 2 2 CHAR

A placeholder field (effective with Version H)

for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID-CD

DB2 ALIAS : HLTH_PLANID_CD
SAS ALIAS : PLANIDCD
STANDARD ALIAS : CLM_HLTH_PLANID_CD
TITLE ALIAS : PLANID_TYPE

LENGTH : 1

COMMENTS :
Prior to Version I this field was named: CLM_PAYERID_CD.

SOURCE : CWF

CODE TABLE : CLM_HLTH_PLANID_TB

144. Claim Health PlanID Number

14 3 16 CHAR

A placeholder field (effective with Version H)

for storing the Health PlanID number. Prior to Version 'I' this field was named:

CLM_PAYERID_NUM.

DB2 ALIAS : HLTH_PLANID_NUM
SAS ALIAS : PLANID
STANDARD ALIAS : CLM_HLTH_PLANID_NUM
TITLE ALIAS : PLANID

LENGTH : 14

COMMENTS :
Prior to Version I this field was named: CLM_PAYERID_NUM.

SOURCE : CWF

145. Claim Demonstration Identification Group
18 1 18 GRP

The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.

STANDARD ALIAS : CLM_DEMO_ID_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : HHA_CLM_DEMO_ID_CNT

146. NCH Demonstration Trailer Indicator Code
1 1 1 CHAR

Effective with Version H, the code indicating the presence of a demo trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

COBOL ALIAS : DEMO_IND
DB2 ALIAS : NCH_DEMO_TRLR_IND_
SAS ALIAS : DEMOIND
STANDARD ALIAS : NCH_DEMO_TRLR_IND_CD
TITLE ALIAS : DEMO_INDICATOR

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_DEMO_TRLR_IND_TB

147. Claim Demonstration Identification Number
2 2 3 CHAR

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appro- private either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a

weekly after was phase # CWF ID date (stored position,	RUGS indicator and one or more revenue center codes in the 9,000 series. NOTE1: Effective for SNF claims with NCH process date after 2/8/96 (and service date 12/31/95) -- beginning 4/97, Demo ID '01' derived in NCH based on presence of RUGS '2','3' or '4' on incoming claim; since 7/97, has been adding ID to claim. NOTE2: During the Version H conversion, Demo '01' was populated back to NCH weekly process 2/9/96 based on the RUGS phase indicator in Claim Edit Group, 3rd occurrence, 4th in Version G).
weekly HCFA/ start/ ID	02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care. NOTE1: Effective for HHA claims with NCH process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on CHPP-supplied listing of provider # and stop dates of participants. NOTE2: During the Version H conversion, Demo '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.
tradi- inter- (nonDMERC) 12/31/96 7/97, '03' 1/97 or more	03 = Telemedicine Demo -- testing covering tionally noncovered physician services for medical consultation furnished via two-way, active video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code. NOTE1: Effective for physician/supplier claims with NCH weekly process date after (and service date after 9/30/96) -- since CWF has been adding Demo ID '03' to claim. NOTE2: During Version H conversion, Demo ID was populated back to NCH weekly process date based on the presence of 'QQ' HCPCS on one line items.
Managed demo, hospital contain	04 = United Mine Workers of America (UMWA) Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 desig- nated counties in 3 states. Under the UMWA will waive the 3-day qualifying stay for a SNF admission. The claims

TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented

for

all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any

Demo

ID '04' annotated claims until on or about

2/98.

05 = Medicare Choices (MCO encounter data)

demo --

testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.

NOTE1: Effective for all claim types with

NCH

weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presence

of

the MCO Plan Contract #. ***Demonstration

was

terminated 12/31/2000.***

NOTE2: During the Version H conversion, Demo

ID

'05' was populated back to NCH weekly process date 8/97 based on the presence of the

Choices

indicator (stored as an alpha character

cross-

walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo

--

testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit

Date

no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the

claim.

The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from parti-cipating hospitals. ***Demo terminated in 1998.***

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the

follow-

ing criteria: Inpatient - presence of DRG

'106'

or '107' and a provider number=220897,

150897,

380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number

=00700/31143

00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

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carrier will

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07 = Virginia Cardiac Surgery Initiative
(formerly referred to as Medicare Quality
ships Demo) -- this is a voluntary
the cardiac surgery physician groups and the
Veterans Administration hospitals providing
heart surgical services in the Commonwealth
Virginia. The goal of the demo is to share
quality and process innovations in an attempt
improve the care for all cardiac patients.
demonstration only affects those FIs that
claims from hospitals in Virginia and the
that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global
basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims
contain a DRG '104', '105', '106', '107',
the related physician/supplier claims will
the claim payment denial reason code = 'D'.
NOTE: The implementation date for this demo
The FI will annotate the claim with the demo
add Demo ID '07' to claim. For carrier
Standard Systems will annotate the claim with
'07' demo number.

08 = Provider Partnership Demo -- testing
payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital
for all Part A and Part B services
with a hospital admission. From 3 to 6
in the Northeast and Mid-Atlantic regions may participate in the demo.
NOTE: The demo is on HOLD. The FI and
add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data)
testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.
NOTE: Effective 10/1/97 (but not actually
mented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15'
claim based on the presence of the MCO plan contract #.

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

NOTE: Effective for all claim types (except with NCH weekly process date after 2/27/98 service date after 10/31/97) -- the FI adds '30' based on the presence of a condition the participating physician (not the carrier) ID to the noninstitutional claim. DUE TO THE SITIVE NATURE OF THIS CLINICAL TRIAL AND TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED HCFA BUT NOT STORED IN THE NEARLINE FILE is restricted to study evaluators only).

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

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

NOTE: All claims will be processed by no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the of this demonstration is to study the impact and health outcomes of applying disease services supplemented with coverage for drugs for certain Medicare beneficiaries with nosed, advanced-stage congestive heart diabetes, or coronary heart disease. Three stration sites will be used for this and it will last for 3 years. (Effective

NOTE: All claims will be processed by NHIC-

DMERC)
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Demo ID
code = EY;
adds
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UNDER THE
THESE
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carriers;

purpose
on costs
management
prescription
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4/1/2003).

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NOEs.

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encounter
Center (HDC).
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which
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encounter claims.

Claims -- The
processing
claims
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claims.

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IHS
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This

Medicare

institutional and

purpose
of the
medical
beneficiaries as
services
beneficiaries
in not

(Carrier). FIs will only serve as a conduit
mitting information to and from CWF about the

38 = Physician Encounter Claims - the purpose
demo id is to identify the physician
claims being processed at the HCFA Data
This number will help EDS in making the
through the appropriate processing logic,
differs from that for fee-for-service.
IN NCH.**
NOTE: Effective October, 2000. Demo ids will
assigned to Inpatient and Outpatient

39 = Centralized Billing of Flu and PPV
purpose of this demo is to facilitate the
carrier, Trailblazers, paying flu and PPV
based on payment localities. Providers will
giving the shots throughout the country and
mitting the claims to Trailblazers for

NOTE: Effective October, 2000 for carrier

40 = Payment of Physician and Nonphysician
in certain Indian Providers -- the purpose of
this demo is to extend payment for services
physician and nonphysician practitioners
furnished in hospitals and ambulatory care
Prior to the legislation change in BIPA,
bursement for Medicare services provided in
facilities was limited to services provided
hospitals and skilled nursing facilities.
change will allow payment for IHS, Tribe and
Tribal Organization providers under the
physician fee schedule.
NOTE: Effective July 1, 2001 for
carrier claims.
48 = Medical Adult Day-Care Services -- the
of this demonstration is to provide, as part
episode of care for home health services,
adult day care services to Medicare
a substitute for a portion of home health
that would otherwise be provided in the
home. This demo would last approx. 3 years
more than 5 sites. Payment for each home

health ser-
the amount
services

claims.

148. Claim Demonstration Information Text
15 4 18 CHAR

that
example,
would
first

contain
RUGS phase
field
'G', RUGS
Group,

field
equal to

field will
HCPCS is

contain
present.
text

will con-

vice episode of care will be set at 95% of
that would otherwise be paid for home health
provided entirely in the home.
NOTE: Effective July 5, 2005 for HHA

DB2 ALIAS : CLM_DEMO_ID_NUM
SAS ALIAS : DEMONUM
STANDARD ALIAS : CLM_DEMO_ID_NUM
TITLE ALIAS : DEMO_ID

LENGTH : 2

SOURCE : CWF

Effective with Version H, the text field
contains related demo information. For
a claim involving a CHOICES demo id '05'
contain the MCO plan contract number in the
five positions of this text field.

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2 ALIAS : CLM_DEMO_INFO_TXT
SAS ALIAS : DEMOTXT
STANDARD ALIAS : CLM_DEMO_INFO_TXT
TITLE ALIAS : DEMO_INFO

LENGTH : 15

DERIVATIONS :
DERIVATION RULES:
Demo ID = 01 (RUGS) -- the text field will
a 2, 3 or 4 to denote the RUGS phase. If
is blank or not one of the above the text
will reflect 'INVALID'. NOTE: In Version
phase was stored in redefined Claim Edit
3rd occurrence, 4th position.
Demo ID = 02 (Home Health demo) -- the text
will contain PROV#. When demo number not
02 then text will reflect 'INVALID'.
Demo ID = 03 (Telemedicine demo) -- text
contain the HCPCS code. If the required
not shown then the text field will reflect
'INVALID'.
Demo ID = 04 (UMWA) -- text field will
W0 denoting that condition code W0 was
If condition code W0 not present then the
field will reflect 'INVALID'.
Demo ID = 05 (CHOICES) -- the text field
tain the CHOICES plan number, if both of the

follow-
number
that 1st
the
effective/termination
within
CHOICES
will
re-
ID is
field
ESRD/
will
ing conditions are met: (1) CHOICES plan
present and PPS or Inpatient claim shows
3 positions of provider number as '210' and
admission date is within HMO
date; or non-PPS claim and the from date is
HMO effective/termination date and (2)
plan number matches the HMO plan number. If either condition is not met the text field
reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will
flect 'INVALID'.
NOTE: In Version 'G', a valid CHOICES plan
stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.
Demo ID = 15 (ESRD Managed Care) -- text
will contain the ESRD/MCO plan number. If
MCO plan number not present the field will reflect 'INVALID'.
Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field
reflect 'INVALID'.

SOURCE : CWF

LIMITATIONS :

REFER TO :
CHOICES_DEMO_LIM

149. Claim Diagnosis Group 7 1 7 GRP

occurrence.
cause
is
also
The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first
The 'E' code (ICD-9-CM code for the external
of an injury, poisoning, or adverse affect)
stored as the last occurrence.
The principal diagnosis and the 'E' code are
stored (redundantly) in the fixed portion of the record.

NOTE:
Prior to Version H this group was named: CLM_OTHR_DGNS_GRP and did not contain the CLM_PRNCPAL_DGNS_CD.

STANDARD ALIAS : CLM_DGNS_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : HHA_CLM_DGNS_CD_CNT

150. NCH Diagnosis Trailer Indicator Code 1 1 1 CHAR

Effective with Version H, the code indicating

the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : DGNS_TRLR_IND_CD
SAS ALIAS : DGNSIND
STANDARD ALIAS : NCH_DGNS_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_DGNS_TRLR_IND_TB

151. Claim Diagnosis Code

5	2	6	CHAR

The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

DB2 ALIAS : CLM_DGNS_CD
SAS ALIAS : DGNS_CD
STANDARD ALIAS : CLM_DGNS_CD
TITLE ALIAS : DIAGNOSIS

LENGTH : 5

COMMENTS :
Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

EDIT RULES :
ICD-9-CM

152. FILLER

1	7	7	CHAR

DB2 ALIAS : FILLER

LENGTH : 1

153. Claim Related Condition Group

3	1	3	GRP

The number of claim related condition trailers is determined by the claim related condition code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM_RLT_COND_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HHA_CLM_RLT_COND_CD_CNT

154. NCH Condition Trailer Indicator Code

1	1	1	CHAR

Effective with Version H, the code indicating the presence of a condition code trailer.

NOTE: During the Version H conversion this field

service

was populated throughout history (back to year 1991).

DB2 ALIAS : COND_TRLR_IND_CD
SAS ALIAS : CONDIND
STANDARD ALIAS : NCH_COND_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_COND_TRLR_IND_TB

155. Claim Related Condition Code

2	2	3	CHAR

to

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

DB2 ALIAS : CLM_RLT_COND_CD
SAS ALIAS : RLT_COND
STANDARD ALIAS : CLM_RLT_COND_CD
TITLE ALIAS : RELATED_CONDITION_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_RLT_COND_TB

156. Claim Related Occurrence Group

11	1	11	GRP

trailers is
code count.
reported
up to 10

The number of claim related occurrence determined by the claim related occurrence Effective 10/93, up to 30 occurrences can be on an institutional claim. Prior to 10/93, occurrences could be reported.

STANDARD ALIAS : CLM_RLT_OCRNC_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HHA_CLM_RLT_OCRNC_CD_CNT

157. NCH Occurrence Trailer Indicator Code

1	1	1	CHAR

Effective with Version H, the code indicating the presence of a occurrence code trailer.

field
service

NOTE: During the Version H conversion this was populated throughout history (back to year 1991).

DB2 ALIAS : OCRNC_TRLR_IND_CD
SAS ALIAS : OCRNCIND
STANDARD ALIAS : NCH_OCRNC_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_OCRNC_TRLR_IND_TB

158. Claim Related Occurrence Code

2	2	3	CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are

claim-related occurrences that are related to a specific date.

DB2 ALIAS : CLM_RLT_OCRNC_CD
SAS ALIAS : OCRNC_CD
STANDARD ALIAS : CLM_RLT_OCRNC_CD
TITLE ALIAS : OCCURRENCE_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_RLT_OCRNC_TB

159. Claim Related Occurrence Date 8 4 11 NUM

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

DB2 ALIAS : CLM_RLT_OCRNC_DT
SAS ALIAS : OCRNCDT
STANDARD ALIAS : CLM_RLT_OCRNC_DT
TITLE ALIAS : RLT_OCRNC_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

160. Claim Occurrence Span Group 19 1 19 GRP

The number of claim occurrence span trailers is determined by the claim occurrence span code count.

Up to 10 occurrences may be reported on an institutional claim.

STANDARD ALIAS : CLM_OCRNC_SPAN_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : HHA_CLM_OCRNC_SPAN_CD_CNT

161. NCH Span Trailer Indicator Code 1 1 1 CHAR

Effective with Version H, the code indicating the presence of a span code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : SPAN_TRLR_IND_CD
SAS ALIAS : SPANIND
STANDARD ALIAS : NCH_SPAN_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_SPAN_TRLR_IND_TB

162. Claim Occurrence Span Code 2 2 3 CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a time period (span of dates).

DB2 ALIAS : CLM_OCRNC_SPAN_CD
SAS ALIAS : SPAN_CD
STANDARD ALIAS : CLM_OCRNC_SPAN_CD
TITLE ALIAS : SPAN_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_OCRNC_SPAN_TB

163. Claim Occurrence Span From Date

8 4 11 NUM

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

DB2 ALIAS : OCRNC_SPAN_FROM_DT
SAS ALIAS : SPANFROM
STANDARD ALIAS : CLM_OCRNC_SPAN_FROM_DT
TITLE ALIAS : SPAN_FROM_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

164. Claim Occurrence Span Through Date

8 12 19 NUM

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

DB2 ALIAS : OCRNC_SPAN_THRU_DT
SAS ALIAS : SPANTHRU
STANDARD ALIAS : CLM_OCRNC_SPAN_THRU_DT
TITLE ALIAS : SPAN_THRU_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

165. Claim Value Group

9 1 9 GRP

present is
Effective
on an
10

The number of claim value data trailers determined by the claim value code count. 10/93, up to 36 occurrences can be reported institutional claim. Prior to 10/93, up to occurrences could be reported.

STANDARD ALIAS : CLM_VAL_GRP

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : HHA_CLM_VAL_CD_CNT

166. NCH Value Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a value code trailer.

field
service

NOTE: During the Version H conversion this was populated throughout history (back to

year 1991).

DB2 ALIAS : VAL_TRLR_IND_CD
SAS ALIAS : VALIND
STANDARD ALIAS : NCH_VAL_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_VAL_TRLR_IND_TB

167. Claim Value Code

2 2 3 CHAR

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

DB2 ALIAS : CLM_VAL_CD
SAS ALIAS : VAL_CD
STANDARD ALIAS : CLM_VAL_CD
TITLE ALIAS : VALUE_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_VAL_TB

168. Claim Value Amount

6 4 9 PACK

The amount related to the condition

identified

in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.

DB2 ALIAS : CLM_VAL_AMT
SAS ALIAS : VAL_AMT
STANDARD ALIAS : CLM_VAL_AMT
TITLE ALIAS : VALUE_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :
$$$$$$$$$CC

169. Claim Revenue Center Group

224 1 224 GRP

The number of claim revenue center data

trailers is

determined by the claim revenue center code

count.

Effective 7/7/00, up to 450 occurrences may

be reported

for an institutional claim. The increase in

the

number of revenue center lines causes each

claim to

be broken out into records/segments (up to

10). Each

record can have up to 45 occurrences of

revenue center

lines. Prior to 7/7/00, up to 58 occurrences

may be

reported on an institutional claim. Claims

submitted

prior to 10/93, contained up to 28

occurrences.

STANDARD ALIAS : CLM_REV_CNTR_GRP

COMMENTS :
********** FOR SNF PPS

****

will be
services.
beginning on or
transitioning by
payment

of
needs, using
known as
III.
Minimum Data
Instrument
groups.

The Balanced Budget Act modified how payment made for skilled nursing facility (SNF) Effective with cost reporting periods after 7/1/98 (with all providers 6/30/99, SNFs will be paid on a prospective system (PPS).
SNFs will classify beneficiaries on the basis residents' characteristics and resource the 44-group patient classification system Resource Utilization Groups (RUGS), Version Facilities will use information from the Set (MDS), Version 2.0, Resident Assesment (RAI) to classify residents into the RUG-III

OCCURS MIN: 0 OCCURS MAX: 45
DEPENDING ON : HHA_REV_CNTR_CD_I_CNT

170. NCH Revenue Center Trailer Indicator Code
1 1 1 CHAR

identifying the

was
to

Effective with Version H, the code revenue center trailer.
During the Version H conversion this field populated with data throughout history (back service year 1991).

DB2 ALIAS : REV_CNTR_TRLR_CD
SAS ALIAS : REVIND
STANDARD ALIAS : NCH_REV_CNTR_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_REV_TRLR_IND_TB

171. Revenue Center Code
4 2 5 CHAR

cost center for
accommodation or
unit within a
pathology).
represents the total of

The provider-assigned revenue code for each which a separate charge is billed (type of ancillary). A cost center is a division or hospital (e.g., radiology, emergency room, EXCEPTION: Revenue center code 0001 all revenue centers included on the claim.

COBOL ALIAS : REV_CD
DB2 ALIAS : REV_CNTR_CD
SAS ALIAS : REV_CNTR
STANDARD ALIAS : REV_CNTR_CD
TITLE ALIAS : REVENUE_CENTER_CD

LENGTH : 4

SOURCE : CWF

CODE TABLE : REV CNTR TB

172. Revenue Center Date 8 6 13 NUM

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date re-presents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the service date represents the date of the first service under the revised plan of treatment.

DB2 ALIAS : REV_CNTR_DT
STANDARD ALIAS : REV_CNTR_DT
TITLE ALIAS : REV_CNTR_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

173. Revenue Center 1st ANSI Code 5 14 18 CHAR

The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals

located
Critical

outpatient
certain
that are
those

hospitals and
services

date
data.

in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward. NOTE2: Beginning with NCH weekly process 7/7/00, this field will be populated with Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV_CNTR_ANSI1_CD
SAS ALIAS : REVANSI1
STANDARD ALIAS : REV_CNTR_ANSI_1_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV_CNTR_ANSI_TB

174. Revenue Center 2nd ANSI Code 5 19 23 CHAR

The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). NOTE1: This field is populated for those

claims
Outpatient
required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services

date
data.

that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward. NOTE2: Beginning with NCH weekly process 7/7/00, this field will be populated with Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV_CNTR_ANSI2_CD
SAS ALIAS : REVANSI2
STANDARD ALIAS : REV_CNTR_ANSI_2_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

175. Revenue Center 3rd ANSI Code

5	24	28	CHAR

The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if outpatient certain HCPCS are on the bill; and any that are type of bill with a condition code '07' and those HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field.

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

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV_CNTR_ANSI3_CD
SAS ALIAS : REVANSI3
STANDARD ALIAS : REV_CNTR_ANSI_3_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

176. Revenue Center 4th ANSI Code

5	29	33	CHAR

The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if

outpatient
certain
that are
those

hospitals and
services

date
data.

certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward. NOTE2: Beginning with NCH weekly process 7/7/00, this field will be populated with Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV_CNTR_ANSI4_CD
SAS ALIAS : REVANSI4
STANDARD ALIAS : REV_CNTR_ANSI_4_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

177. Revenue Center APC/HIPPS Code 5 34 38 CHAR

created
Payment
code. The APC
services. APC
services under
HIPPS codes
for SNFPPS,
calculate payment.

claims
Outpatient
required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services

Effective with Version 'I', this field was to house two pieces of data. The Ambulatory Classification (APC) code and the HIPPS is used to identify groupings of outpatient codes are used to calculate payment for OPPS. The APC is a four byte field. The are used to identify patient classifications HHPPS and IRFPPS that will be used to The HIPPS code is a five byte field. NOTE1: The APC field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward.

codes
if a
downcoded/

date
data.
contain

NOTE2: Under SNFPPS, HHPPS & IRFPPS, HIPPS are stored in the HCPCS field. **EXCEPTION: HHPPS HIPPS code is downcoded/upcoded the upcoded HIPPS will be stored in this field.
NOTE3: Beginning with NCH weekly process 8/18/00, this field will be populated with Claims processed prior to 8/18/00 will spaces in this field.

DB2 ALIAS : REV_APC_HIPPS_CD S
SAS ALIAS : APCHIPPS
STANDARD ALIAS : REV_CNTR_APC_HIPPS_CD
TITLE ALIAS : APC_HIPPS

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV_CNTR_APC_TB

178. Revenue Center Healthcare Common Procedure Coding System Code 5 39 43 CHAR

(HCPCS)
procedures,

Healthcare Common Procedure Coding System is a collection of codes that represent 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:

DB2 ALIAS : REV_CNTR_HCPCS_CD
STANDARD ALIAS : REV_CNTR_HCPCS_CD
TITLE ALIAS : HCPCS_CD

LENGTH : 5

COMMENTS :
Prior to Version H this field was named: HCPCS_CD. With Version H, a prefix was added to denote the location of this

field
and

PPS),
field
code.

code/
group
RAI
type of

identifies
HHRG system,
which a

on each claim type (institutional: REV_CNTR non-institutional: LINE).
NOTE: When revenue center code = '0022' (SNF '0023' (HH PPS), or '0024' (IRF PPS); this contains the Health Insurance PPS (HIPPS)

The HIPPS code for SNF PPS contains the rate assessment type that identifies (1) RUG-III the beneficiary was classified into as of the MDS assessment reference date and (2) the assessment for payment purposes.
The HIPPS code for Home Health PPS (1) the three case-mix dimensions of the clinical, functional and utilization, from beneficiary is assigned to one of the 80 HHRG

not
derived.
will be

identifies
beneficiary.
contain
is an
with an
without comor-
defined as
defined
as
HIPPS
Code
system

see

American

are
physician

the
the

Dental
are

jointly
(consisting

and

level.

categories and (2) it identifies whether or
the elements of the code were computed or
The HHRGs, represented by the HIPPS coding,
the basis of payment for each episode.
The HIPPS code (CMG Code) for IRF PPS
the clinical characteristics of the
The HIPPS rate/CMG code (AXXYY - DXXYY) must
five digits. The first position of the code
A, B, C, or 'D'. The HIPPS code beginning
'A' in front of the CMG is defined as
bidity. The 'B' in front of the CMG is
with comorbidity for Tier 1. The 'C' is
as comorbidity for Tier 2 and 'D' is defined
comorbidity for Tier 3. The 'XX' in the
rate code is the Rehabilitation Impairment
(RIC). The 'YY' is the sequential number
within the RIC.
For SNF PPS, HH PPS & IRF PPS HIPPS values
CLM_HIPPS_TB.

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

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

Level II
Includes codes and descriptors copyrighted by
the American Dental Association's Current
Terminology, Second Edition (CDT-2). These
5 position alpha-numeric codes comprising
the D series. All other level II codes and
descriptors are approved and maintained
by the alpha-numeric editorial panel
of HCFA, the Health Insurance Association of
America, and the Blue Cross and Blue Shield
Association). These are 5 position alpha-
numeric codes representing primarily items
nonphysician services that are not
represented in the level I codes.

Level III
Codes and descriptors developed by Medicare
carriers for use at the local (carrier)
These are 5 position alpha-numeric codes in

the

W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

LIMITATIONS :

REFER TO :
HHA_HCPCS_LIM

CODE TABLE : CLM_HIPPS_TB

179. Revenue Center HCPCS Initial Modifier Code
2 44 45 CHAR

A first modifier to the procedure code to

enable a more

specific procedure identification for the

claim.

DB2 ALIAS : REV_HCPCS_MDFR_CD
STANDARD ALIAS : REV_CNTR_HCPCS_INITL_MDFR_CD
TITLE ALIAS : INITIAL_MODIFIER

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: HCPCS_INITL_MDFR_CD. With Version H, a

prefix

was added to denote the location of this

field

on each claim type (institutional: REV_CNTR

and

non-institutional: LINE).

SOURCE : CWF

EDIT RULES :
Carrier Information File

180. Revenue Center HCPCS Second Modifier Code
2 46 47 CHAR

A second modifier to the procedure code to

make it more

specific than the first modifier code to

identify the

procedures performed on the beneficiary for

the claim.

DB2 ALIAS : REV_HCPCS_2ND_CD
STANDARD ALIAS : REV_CNTR_HCPCS_2ND_MDFR_CD
TITLE ALIAS : SECOND_MODIFIER

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: HCPCS_2ND_MDFR_CD. With Version H, a prefix was added to denote the location of this

field

on each claim type (institutional: REV_CNTR

and

non-institutional: LINE).

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

181. Revenue Center HCPCS Third Modifier Code
2 48 49 CHAR

Effective with Version I, a third modifier to

the

procedure code to make it more specific

than the

second modifier code to identify the

procedures

performed on the beneficiary for the claim.

DB2 ALIAS : REV_HCPCS_3RD_CD
STANDARD ALIAS : REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS : THIRD_MODIFIER

LENGTH : 2

COMMENTS :
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with

data.

Claims processed prior to 8/18/00 will

contain

spaces in this field.

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

182. Revenue Center HCPCS Fourth Modifier Code
2 50 51 CHAR

Effective with Version I, a fourth modifier

to the

procedure code to make it more specific than

the

third modifier code to identify the

procedures

performed on the beneficiary for the claim.

DB2 ALIAS : REV_HCPCS_4TH_CD
STANDARD ALIAS : REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE ALIAS : FOURTH_MODIFIER

LENGTH : 2

COMMENTS :
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with

data.

Claims processed prior to 8/18/00 will

contain

spaces in this field.

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

183. Revenue Center HCPCS Fifth Modifier Code
2 52 53 CHAR

Effective with Version I, a fifth modifier to

the

procedure code to make it more specific than

the

fourth modifier code to identify the

procedures

performed on the beneficiary for the claim.

DB2 ALIAS : REV_HCPCS_5TH_CD
SAS ALIAS : MDFR_CD5
STANDARD ALIAS : REV_CNTR_HCPCS_5TH_MDFR_CD
TITLE ALIAS : FIFTH_MODIFIER

LENGTH : 2

COMMENTS :
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with

data.

Claims processed prior to 8/18/00 will

contain

spaces in this field.

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

184. Revenue Center Payment Method Indicator Code
2 54 55 CHAR

Effective with Version 'I', the code used to identify how the service is priced for

payment.

This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

NOTE1: This field is populated for those

claims

that are required to process through

Outpatient

PPS Pricer. The type of bills (TOB)

required to

process through are: 12X, 13X, 14X (except

Maryland

providers, Indian Health Providers, hospitals

located

in American Samoa, Guam and Saipan and

Critical

Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any

outpatient

type of bill with a condition code '07' and

certain

HCPCS. These claim types could have lines

that are

not required to price under OPPS rules so

those

lines would not have data in this field.

Additional exception: Virgin Island

hospitals and

hospitals that furnish only inpatient Part B

services

with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this

field may be

populated with data on claims with dates of

service

prior to 7/00 (implementation of Claim Line

Expansion

OPPS/HHPPS). The original understanding of

the new

revenue center fields was that data would be

populated

on claims with dates of service 7/00 and

forward. Data

has been found in claims with dates of

service prior to

7/00 because the Standard Systems have

processed any

claim coming in 7/00 and after, meeting the

above criteria,

through the Outpatient Code Editor (OCE)

regardless of the

dates of service.

NOTE3: Effective 10/2005, this field will no

longer

represent the service indicator and the

payment

indicator. This field will now house the 2-

byte

payment indicator. The status indicator will

be housed

in a new field named: REV_CNTR_STUS_IND_CD.

DB2 ALIAS : REV_PMT_MTHD_CD
SAS ALIAS : PMTMTHD
STANDARD ALIAS : REV_CNTR_PMT_MTHD_IND_CD
TITLE ALIAS : PMT_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV CNTR PMT MTHD IND TB

185. Revenue Center Discount Indicator Code

1	56	56	CHAR

Effective with Version 'I', this code represents a factor that specifies the amount of any APC (part of the REV_CNTR_PMT_MTHD_IND_CD) discount. The discounting factor is applied of 'T'. The significant flag is applicable when more than one dis- procedure is performed. **If there is no claims counting the factor will be 1.0.**

NOTE1: This field is populated for those Outpatient that are required to process through required to PPS Pricer. The type of bills (TOB) Maryland process through are: 12X, 13X, 14X (except located providers, Indian Health Providers, hospitals Critical in American Samoa, Guam and Saipan and outpatient Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any that are type of bill with a condition code '07' and those HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

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

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:

D = Discounting fraction (currently 0.5)
U = Number of units
T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV_DSCNT_IND_CD
SAS ALIAS : DSCNTIND
STANDARD ALIAS : REV_CNTR_DSCNT_IND_CD
TITLE ALIAS : REV_CNTR_DSCNT_IND_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_DSCNT_IND_TB

186. Revenue Center Packaging Indicator Code

1 57 57 CHAR

Effective with Version 'I', the code used to identify those services that are packaged/ bundled with another service.

NOTE1: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward.

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

DB2 ALIAS : REV_PACKG_IND_CD
SAS ALIAS : PACKGIND
STANDARD ALIAS : REV_CNTR_PACKG_IND_CD
TITLE ALIAS : REV_CNTR_PACKG_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_PACKG_IND_TB

187. Revenue Center Pricing Indicator Code

2 58 59 CHAR

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

claims
Outpatient
required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services

field may be
service
Expansion
the new
populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

NOTE1: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward. NOTE2: It has been discovered that this populated with data on claims with dates of prior to 7/00 (implementation of Claim Line OPPS/HHPPS). The original understanding of revenue center fields was that data would be on claims with dates of service 7/00 and has been found in claims with dates of 7/00 because the Standard Systems have claim coming in 7/00 and after, meeting the through the Outpatient Code Editor (OCE) dates of service.

DB2 ALIAS : REV_PRICNG_IND_CD
SAS ALIAS : PRICNG
STANDARD ALIAS : REV_CNTR_PRICNG_IND_CD
TITLE ALIAS : REV_CNTR_PRICNG_IND

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_PRICNG_IND_TB

188. Revenue Center Obligation to Accept As Full (OTAF) Payment Code
1 60 60 CHAR

Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

claims
Outpatient
required to
Maryland
located

NOTE1: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals

Critical

outpatient

certain

that are

those

hospitals and

services

field may be

service

Expansion

the new

populated

forward. Data

service prior to

processed any

above criteria,

regardless of the

payment

service.

obligated to accept

payment by a prior

in American Samoa, Guam and Saipan and

Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any

type of bill with a condition code '07' and

HCPCS. These claim types could have lines

not required to price under OPPS rules so

lines would not have data in this field.

Additional exception: Virgin Island

hospitals that furnish only inpatient Part B

with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this

populated with data on claims with dates of

prior to 7/00 (implementation of Claim Line

OPPS/HHPPS). The original understanding of

revenue center fields was that data would be

on claims with dates of service 7/00 and

has been found in claims with dates of

7/00 because the Standard Systems have

claim coming in 7/00 and after, meeting the

through the Outpatient Code Editor (OCE)

dates of service.

DB2 ALIAS : REV_OTAF1_IND_CD
SAS ALIAS : OTAF_1
STANDARD ALIAS : REV_CNTR_OTAF_1_IND_CD
TITLE ALIAS : REV_CNTR_OTAF_1_IND_CD

LENGTH : 1

SOURCE : CWF

EDIT RULES :
Y = provider is obligated to accept the as payment in full for the
N or blank = provider is not the payment, or there is no payer.

189. Revenue Center Obligation to Accept As Full (OTAF) Payment Code
1 61 61 CHAR

**********FIELD NOT POPULATED**********
This field was intended to collect

information

for two payers if Medicare was tertiary. It

with

was discovered that MSP system only deals

one payer so there is no need to have 2 OTAF

fields.

DB2 ALIAS : REV_OTAF2_IND_CD
SAS ALIAS : OTAF_2
STANDARD ALIAS : REV_CNTR_OTAF_2_IND_CD
TITLE ALIAS : REV_CNTR_OTAF_2_IND_CD

LENGTH : 1

SOURCE : CWF

190. Revenue Center IDE, NDC, UPC Number 24 62 85 CHAR

number
(FDA)
manufacturer
clinical
new

service

store
fields:
second
can be
an
con-
'0624'

field was
National Drug Code
This field
would never
come in on
expanded to X(24)
(under Version
During an
missing.
weekly pro-
processing
IDE but

Effective with Version H, the exemption assigned by the Food and Drug Administration to an investigational device after a has been approved by FDA to conduct a trial on that device. HCFA established a policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to IDE's. The IDE number was housed in two HCPCS code and HCPCS initial modifier; the modifier contained the value 'ID'. There up to 7 distinct IDE numbers associated with '0624' dummy trailer. During the Version H version IDE's were moved from the dummy trailer to this dedicated field.

NOTE2: Effective with Version 'I', this renamed to eventually accommodate the (NDC) and the Universal Product Code (UPC). could contain either of these 3 fields (there be an instance where more than one would a claim). The size of this field was to accommodate either of the new fields 'H' it was X(7). DATA ANAMOLY/LIMITATION: CWFMQA review an edit revealed the IDE was The problem occurs in claim with an NCH cess dates of 6/9/00 through 9/8/00. During of the new format the program receives the then blanked out the data.

DB2 ALIAS : IDE_NDC_UPC_NUM
SAS ALIAS : IDENDC
STANDARD ALIAS : REV_CNTR_IDE_NDC_UPC_NUM
TITLE ALIAS : IDE_NDC_UPC

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :
REV_CNTR_IDE_NDC_UPC_LIM

191. Revenue Center Unit Count 4 86 89 PACK

of times the
performed according
as described on

measured by number
accommodation, pints of
dialysis
therapy visits,
tests.

(SNF PPS) the unit
for each HIPPS
for each rehab

A quantitative measure (unit) of the number
service or procedure being reported was
to the revenue center/HCPCS code definition
an institutional claim.
Depending on type of service, units are
of covered days in a particular
blood, emergency room visits, clinic visits,
treatments (sessions or days), outpatient
and outpatient clinical diagnostic laboratory

NOTE1: When revenue center code = '0022'
count will reflect the number of covered days
code and, if applicable, the number of visits
therapy code.

DB2 ALIAS : REV_CNTR_UNIT_CNT
SAS ALIAS : REV_UNIT
STANDARD ALIAS : REV_CNTR_UNIT_CNT
TITLE ALIAS : UNITS

LENGTH : 7 SIGNED : Y

SOURCE : CWF

192. Revenue Center Rate Amount 6 90 95 PACK

(encounter
know
will

center

provider
and
revenue

a
Ambulatory
factor,

rate is
associated with
index

depending on
episode.

Charges relating to unit cost associated with the revenue center code. Exception
data only): If plan (e.g. MCO) does not
the actual rate for the accommodations, $1
be reported in the field.
NOTE1: For SNF PPS claims (when revenue
code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the
supplied coding for the MDS RUGS III group
assessment type (HIPPS code, stored in
center HCPCS code field).
NOTE2: For OP PPS claims, CMS has developed
PRICER to compute the rate based on the
Payment Classification (APC), discount
units of service and the wage index.
NOTE3: Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the
determined using the case mix weight
the HIPPS code, adjusting it for the wage
for the beneficiary's site of service, then multiplying the result by 60% or 50%,
whether or not the RAP is for a first

change the
or
adjustment.
one
the

center
PRICER
code

was:

193. Revenue Center Blood Deductible Amount
6 96 101 PACK

money
deductible

claims
Outpatient
required to
Maryland
located
Critical
outpatient
certain
that are
those

hospitals and
services

field may be
service
Expansion

On the final claim, the HIPPS code could
payment if the therapy threshold is not met,
partial episode payment (PEP) adjustment or a
significant change in condition (SCIC)
In cases of SCICs, there will be more than
'0023' revenue center line, each representing
payment made at each case-mix level.
NOTE4: For IRF PPS claims (when revenue
code equals '0024'), CMS has developed a
to compute the rate based on the HIPPS/CMG
(HIPPS code, stored in revenue center HCPCS
field).

DB2 ALIAS : REV_CNTR_RATE_AMT
SAS ALIAS : REV_RATE
STANDARD ALIAS : REV_CNTR_RATE_AMT
TITLE ALIAS : CHARGE_PER_UNIT

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H the size of this field
S9(7)V99.

SOURCE : CWF

Effective with Version 'I', the amount of
for which the intermediary determined the
beneficiary is liable for the blood
for the line item service.
NOTE1: This field is populated for those
that are required to process through
PPS Pricer. The type of bills (TOB)
process through are: 12X, 13X, 14X (except
providers, Indian Health Providers, hospitals
in American Samoa, Guam and Saipan and
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any
type of bill with a condition code '07' and
HCPCS. These claim types could have lines
not required to price under OPPS rules so
lines would not have data in this field.
Additional exception: Virgin Island
hospitals that furnish only inpatient Part B
with dates of service 1/1/02 and forward.
NOTE2: It has been discovered that this
populated with data on claims with dates of
prior to 7/00 (implementation of Claim Line

the new
populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

OPPS/HHPPS). The original understanding of revenue center fields was that data would be on claims with dates of service 7/00 and has been found in claims with dates of 7/00 because the Standard Systems have claim coming in 7/00 and after, meeting the through the Outpatient Code Editor (OCE) dates of service.

DB2 ALIAS : REV_BLOOD_DDCTBL
SAS ALIAS : REVBLOOD
STANDARD ALIAS : REV_CNTR_BLOOD_DDCTBL_AMT
TITLE ALIAS : BLOOD_DDCTBL_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

194. Revenue Center Cash Deductible Amount
6 102 107 PACK

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

claims
Outpatient
required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services

field may be
service
Expansion
the new
populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

NOTE1: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward.
NOTE2: It has been discovered that this populated with data on claims with dates of prior to 7/00 (implementation of Claim Line OPPS/HHPPS). The original understanding of revenue center fields was that data would be on claims with dates of service 7/00 and has been found in claims with dates of 7/00 because the Standard Systems have claim coming in 7/00 and after, meeting the through the Outpatient Code Editor (OCE)

dates of service.

DB2 ALIAS : REV_CASH_DDCTBL
SAS ALIAS : REVDCTBL
STANDARD ALIAS : REV_CNTR_CASH_DDCTBL_AMT
TITLE ALIAS : CASH_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

195. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount
6 108 113 PACK

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

NOTE2: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : ADJSTD_COINSRNC
SAS ALIAS : WAGEADJ
STANDARD ALIAS :
REV_CNTR_WAGE_ADJSTD_COINS_AMT
TITLE ALIAS : WAGE_ADJSTD_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

196. Revenue Center Reduced Coinsurance Amount

6 114 119 PACK

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if outpatient certain HCPCS are on the bill; and any that are type of bill with a condition code '07' and those HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : RDCD_COINSRNC
SAS ALIAS : RDCDCOIN
STANDARD ALIAS : REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS : REDUCED_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

197. Revenue Center 1st Medicare Secondary Payer Paid Amount

6 120 125 PACK

Effective with Version 'I', the amount paid the primary payer when the payer is primary Medicare (Medicare is secondary).
NOTE1: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field.
Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward.
NOTE2: It has been discovered that this populated with data on claims with dates of prior to 7/00 (implementation of Claim Line OPPS/HHPPS). The original understanding of revenue center fields was that data would be on claims with dates of service 7/00 and has been found in claims with dates of 7/00 because the Standard Systems have claim coming in 7/00 and after, meeting the through the Outpatient Code Editor (OCE) dates of service.

DB2 ALIAS : REV_MSP1_PD_AMT
SAS ALIAS : REV_MSP1
STANDARD ALIAS : REV_CNTR_MSP1_PD_AMT
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

198. Revenue Center 2nd Medicare Secondary Payer Paid Amount

6 126 131 PACK

Effective with Version 'I', the amount paid the secondary payer when two payers are to Medicare (Medicare is the tertiary payer).
NOTE1: This field is populated for those that are required to process through

required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services

field may be
service
Expansion
the new
populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward. NOTE2: It has been discovered that this populated with data on claims with dates of prior to 7/00 (implementation of Claim Line OPPS/HHPPS). The original understanding of revenue center fields was that data would be on claims with dates of service 7/00 and has been found in claims with dates of 7/00 because the Standard Systems have claim coming in 7/00 and after, meeting the through the Outpatient Code Editor (OCE) dates of service.

DB2 ALIAS : REV_MSP2_PD_AMT
SAS ALIAS : REV_MSP2
STANDARD ALIAS : REV_CNTR_MSP2_PD_AMT
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

199. Revenue Center Professional Component Amount
6 132 137 PACK

services

date

charges
items

**********FIELD NOT POPULATED**********
Intended to be populated for line item subject to PPS, as the amount associated with Value Code '05'. However, with line item of service reporting, there is no way to correctly allocate professional component reported in value code '05' to specific line on the claim.

DB2 ALIAS : REV_PROFNL_CMPNT
SAS ALIAS : REVPCCHG
STANDARD ALIAS : REV_CNTR_PROFNL_CMPNT_AMT
TITLE ALIAS : PROFNL_CMPNT_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

200. Revenue Center Provider Payment Amount	6	138	143	PACK

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if outpatient certain HCPCS are on the bill; and any certain type of bill with a condition code '07' and that are HCPCS. These claim types could have lines those not required to price under OPPS rules so lines would not have data in this field.

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

ANAMOLY: For dates of service August 1, 2000 to the present, the OPPS revenue center fields are being processed differently by FISS and APASS OPPS (standard systems). For more information on Limitations data problems for this time period see handles Appendix. The following is how each system this field:

FISS: populated correctly with provider payment amount

APASS: provider payment amount plus interest on 1st revenue center line (CMM will instruct the APASS APASS not to include interest)

Currently, the following FI numbers are under FISS. See system and all other FI numbers are under FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be

populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

on claims with dates of service 7/00 and
has been found in claims with dates of
7/00 because the Standard Systems have
claim coming in 7/00 and after, meeting the
through the Outpatient Code Editor (OCE)
dates of service.

DB2 ALIAS : REV_PRVDR_PMT_AMT
SAS ALIAS : RPRVDPMT
STANDARD ALIAS : REV_CNTR_PRVDR_PMT_AMT
TITLE ALIAS : REV_PRVDR_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

201. Revenue Center Beneficiary Payment Amount
6 144 149 PACK

Effective with Version I, the amount paid to the beneficiary for the services reported on the line item.

claims
Outpatient
required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services

field may be
service
Expansion
the new
populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

NOTE1: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward.
NOTE2: It has been discovered that this populated with data on claims with dates of prior to 7/00 (implementation of Claim Line OPPS/HHPPS). The original understanding of revenue center fields was that data would be on claims with dates of service 7/00 and has been found in claims with dates of 7/00 because the Standard Systems have claim coming in 7/00 and after, meeting the through the Outpatient Code Editor (OCE) dates of service.

DB2 ALIAS : REV BENE PMT AMT

SAS ALIAS : RBENEPMT
STANDARD ALIAS : REV_CNTR_BENE_PMT_AMT
TITLE ALIAS : REV_BENE_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

202. Revenue Center Patient Responsibility Payment Amount
6 150 155 PACK

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if outpatient certain HCPCS are on the bill; and any that are type of bill with a condition code '07' and those HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field.

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

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service

Expansion
the new
populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

prior to 7/00 (implementation of Claim Line OPPS/HHPPS). The original understanding of revenue center fields was that data would be on claims with dates of service 7/00 and has been found in claims with dates of 7/00 because the Standard Systems have claim coming in 7/00 and after, meeting the through the Outpatient Code Editor (OCE) dates of service.

DB2 ALIAS : REV_PTNT_RESP_AMT
SAS ALIAS : PTNTRESP
STANDARD ALIAS : REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS : REV_PTNT_RESP

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

203. Revenue Center Payment Amount 6 156 161 PACK

Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

claims
Outpatient
required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services

to
being
(standard
problems
Appendix. The
field:

reimbursement.

coinsurance and

NOTE1: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field. Additional exception: Virgin Island hospitals that furnish only inpatient Part B with dates of service 1/1/02 and forward. ANAMOLY: For dates of service August 1, 2000 present, the OPPS revenue center fields are processed differently by FISS and APASS systems). For more information on OPPS data for this time period see the Limitations following is how each system is handling this

FISS: this field contains provider

APASS: provider payment amount plus

and

the APASS
FISS. See

3/1/2004)

field may be
service
Expansion
the new
populated
forward. Data
service prior to
processed any
above criteria,
regardless of the

204. Revenue Center Total Charge Amount
6 162 167 PACK

for all
revenue code)
deductible and
for the cost of
revenue center
units (days).

series revenue
customary
to the
have been
participating in the

deductible (should not include coinsurance
deductible). Users should rely on provider payment amount field for the trust fund payment.

Currently, the following FI numbers are under
system and all other FI numbers are under
FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until

00181 -- Maine/Massachusetts (until 5/1/2004)

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

DB2 ALIAS : REV_CNTR_PMT_AMT
SAS ALIAS : REVPMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :
$$$$$$$$$CC

The total charges (covered and non-covered)
accommodations and services (related to the
for a billing period before reduction for the
coinsurance amounts and before an adjustment
services provided. NOTE: For accommodation
total charges must equal the rate times

EXCEPTIONS:
(1) For SNF RUGS demo claims only (9000
center codes), this field contains SNF
accommodation charge, (ie., charges related
accommodation revenue center code that would
applicable if the provider had not been
demo).

revenue center code

center code =
dollar amount for

revenue center
sum of the
'0023').

(IFR) PPS, when
charges will
(010X - 021X),
units.

MCO) does not
accommodations the total

was:

205. Revenue Center Non-Covered Charge Amount
6 168 173

code for

S9(7)V99 and
Inpatient/SNF format.
field was added

REV_CENTER_NONCOVERED_CHARGES

(2) For SNF PPS (non demo claims), when
= '0022', the total charges will be zero.
(3) For Home Health PPS (RAPs), when revenue
'0023', the total charges will equal the
the '0023' line.
(4) For Home Health PPS (final claim), when
code = '0023', the total charges will be the
revenue center code lines (other than

(5) For Inpatient Rehabilitation Facility
the revenue center code = '0024', the total
be zero. For accommodation revenue codes
total charges must equal the rate times the

(6) For encounter data, if the plan (e.g.
know the actual charges for the
charges will be $1 (rate) times units (days).

DB2 ALIAS : REV_TOT_CHRG_AMT
SAS ALIAS : REV_CHRG
STANDARD ALIAS : REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS : REVENUE_CENTER_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H the size of this field
S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :
MLTPL_REV_CNTR_0001_CD_LIM
REV_CNTR_TOT_CHRG_AMT_LIM

EDIT RULES :
$$$$$$$$$CC

PACK
The charge amount related to a revenue center
services that are not covered by Medicare.
NOTE: Prior to Version H the field size was
the element was only present on the
As of NCH weekly process date 10/3/97 this
to all institutional claim types.

DB2 ALIAS : REV_NCVR_CHRG_AMT
SAS ALIAS : REV_NCVR
STANDARD ALIAS : REV_CNTR_NCVR_CHRG_AMT
TITLE ALIAS :

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :

$$$$$$$$$CC

206. Revenue Center Deductible Coinsurance Code
1 174 174 CHAR

charges

Code indicating whether the revenue center are subject to deductible and/or coinsurance.

DB2 ALIAS : DDCTBL_COINSRNC_CD
SAS ALIAS : REVDEDCD
STANDARD ALIAS : REV_CNTR_DDCTBL_COINSRNC_CD
TITLE ALIAS : REVENUE_CENTER_DEDUCTIBLE_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_DDCTBL_COINSRNC_TB

207. Revenue Center Consolidated Billing Code
1 175 175 CHAR

NCH/NMUD
claims only
therapy
subject
If the
prior
claim
be submitted
to

Effective 1/1/2004 with the implementation of CR#1, this code is reflected on outpatient to identify those line item services (i.e. and nonroutine supply services) that are to SNF and Home Health consolidated billing. line item service was paid by an intermediary to the submission of the SNF or home health an adjustment for the outpatient claim will identifying those services that are subject consolidated billing.

NCH/NMUD
(FILLER)

no longer
being handled

NOTE1: Prior to 10/2005 (implementation of CR#2), this data was stored in position 175 in the revenue center trailer.
NOTE2: Effective July 2005, this data will be coming into the NCH. This process is in the new CWF override processing.

DB2 ALIAS : CNSLDTD_BLG_CD
SAS ALIAS : RCNSLDTD
STANDARD ALIAS : REV_CNTR_CNSLDTD_BLG_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_CNSLDTD_BLG_TB

208. Revenue Center Status Indicator Code
2 176 177 CHAR

of NCH/NMUD
of the
the
identify

Effective 10/3/2005 with the implementation CR#2, the code used to identify the status line item service. This field along with payment method indicator field is used to how the service was priced for payment.

due to

NOTE1: This 2-byte indicator is being added an expansion of a field that currently exist

on the
is
Center
method
byte
indicator). The
be stored
field. The
field
date from

claims
Outpatient
required to
Maryland
located
Critical

outpatient
certain
that are
those

hospitals and
services.

209. FILLER	47	178	224
210. End of Record Code	3	1	3

revenue center trailer. The status indicator currently the 1st position of the Revenue Payment Method Indicator Code. The payment indicator code is being split into two 2- fields (payment indicator and status expanded payment indicator will continue to in the existing payment method indicator split of the current payment method indicator is due to the expansion of both pieces of 1-byte to 2-bytes.
NOTE2: This field is populated for those that are required to process through PPS Pricer. The type of bills (TOB) process through are: 12X, 13X, 14X (except providers, Indian Health Providers, hospitals in American Samoa, Guam and Saipan and Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any type of bill with a condition code '07' and HCPCS. These claim types could have lines not required to price under OPPS rules so lines would not have data in this field.
Additional exception: Virgin Island hospitals that furnish only inpatient Part B

DB2 ALIAS : REV_STUS_IND_CD
SAS ALIAS : RSTUSIND
STANDARD ALIAS : REV_CNTR_STUS_IND_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_STUS_IND_TB

CHAR

DB2 ALIAS : FILLER

LENGTH : 47

CHAR

Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.

DB2 ALIAS : END_REC_CD
SAS ALIAS : EOR
STANDARD ALIAS : END_REC_CD
TITLE ALIAS : END_OF_REC

LENGTH : 3

COMMENTS :
Prior to Version I this field was named:

```
                                        END_REC_CNSTNT.
                                        SOURCE          : NCH
                                        CODE TABLE      : END_REC_TB

H3PM.R_RIF_MAIN_Q,Q1,F
```