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## Revision History

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<th>Revision Date</th>
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<tr>
<td>04/26/18</td>
<td>1.0</td>
<td>Initial release of Codebook for Medicare Encounter Records</td>
<td>Kathy Schneider, Rachel VanGilder, Chris Alleman</td>
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<tr>
<td>April 2019</td>
<td>1.1</td>
<td>Added a variable to correspond with the final 2015 Encounter data files: LINE_NUM.ORIG. Edited description for CLM.LINE_NUM.</td>
<td>Kathy Schneider</td>
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<td>December 2019</td>
<td>1.2</td>
<td>Added CLM_PLACE_OF_SRVC_CD and RNDRNG_PHYSN_NPI to Carrier and DME Base Claim layouts for 2016 Encounter data files.</td>
<td>Kathy Schneider</td>
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<tr>
<td>May 2020</td>
<td>1.3</td>
<td>Updated state codes, added REV_CNTR values</td>
<td>Kathy Schneider</td>
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This document is a detailed codebook that describes each variable in the Medicare Encounter Records files. Because the files have such a large number of variables, we have included several ways for analysts to quickly find the information they need.

- A complete listing of all variables in the files, in alphabetical order based on their SAS variable names.

- Individual entries for each variable that contain a short description of the variable, the possible values for the variable, and, in many cases, notes that discuss how the variable was constructed and should be used.

We have included hyperlinks throughout the codebook to make it easier for analysts to navigate between the table of contents and the detailed entries for the individual variables:

- Clicking on any variable name in the Table of Contents will take you to the detailed description for that variable.

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

This section of the Codebook contains a list of all variables in alphabetical order based on the SAS variable name.

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**ADMTG_DGNS_CD**

**LABEL:** Claim Admitting Diagnosis Code

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

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

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base

**VALUES:** -

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.
**AT_PHYSN_NPI**

**LABEL:** Claim Attending Physician NPI Number

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

**TYPE:** CHAR

**LENGTH:** 10

**FILE(S):** IP Base
SNF Base
HH Base
OP Base

**SOURCE:** Medicare Advantage Organizations (MAOs)

**VALUES:** -

**COMMENT:** -
**AT_PHYSN_TXNMY_CD**

**LABEL:** Claim Attending Physician Taxonomy Code

**DESCRIPTION:** The health care provider taxonomy (HCPT) code used to indicate the attending provider's specialty. This is a unique identifier for a classification of health care specialty at a specialized level of defined medical activity within a medical field as created by the National Uniform Claim Committee (NUCC).

**TYPE:** CHAR

**LENGTH:** 10

**FILE(S):** IP Base
SNF Base
HH Base
OP Base

**SOURCE:** Medicare Advantage Organizations (MAOs)

**VALUES:** 10-digit alphanumeric

**COMMENT:** Additional information regarding the meaning of the NUCC taxonomy codes is available on their website. See, for example: [http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40](http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40)
**BENE_CNTY_CD**

**LABEL:** Beneficiary County Code from Claim (SSA)

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

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base  
Carrier Base  
DME Base

**VALUES:** -

**COMMENT:** CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.

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

LABEL: Beneficiary Discharge Date

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

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base
          SNF Base
          HH Base

VALUES: -

COMMENT: -
**BENE_ID**

**LABEL:** Encrypted CCW Beneficiary ID  

**DESCRIPTION:** The unique CCW identifier for a beneficiary.

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

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

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

**TYPE:** CHAR  

**LENGTH:** 15  

**SOURCE:** CCW  

**FILE(S):** All Encounter Files  

**VALUES:** -  

**COMMENT:** -
**BENE_MDCR_STUS_CD**

**LABEL:** Beneficiary Medicare Status Code

**DESCRIPTION:** This variable identifies how a beneficiary qualifies for Medicare benefits as of a particular date.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:**
- 10 = Aged without end-stage renal disease (ESRD)
- 11 = Aged with ESRD
- 20 = Disabled without ESRD
- 21 = Disabled with ESRD
- 31 = ESRD only

**COMMENT:** CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.
**BENE_MLG_CNTCT_ZIP_CD**

**LABEL:** Beneficiary ZIP Code of Residence from Claim

**DESCRIPTION:** The ZIP code of the mailing address where the beneficiary may be contacted. It is the zip 5 and 4-digit extension as submitted on the encounter record.

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base  
Carrier Base  
DME Base

**VALUES:** -

**COMMENT:** -
**BENE_RACE_CD**

**LABEL:** Beneficiary Race Code

**DESCRIPTION:** Race code of the beneficiary

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base
              SNF Base
              HH Base
              OP Base
              Carrier Base
              DME Base

**VALUES:**

0 = Unknown
1 = White
2 = Black
3 = Other
4 = Asian
5 = Hispanic
6 = North American Native

**COMMENT:** CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.
**BENE_STATE**

**LABEL:** State of beneficiary (postal abbreviation)

**DESCRIPTION:** This variable is the two-letter postal abbreviation for the state where the beneficiary lives.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** CMS Common Medicare Environment (CME) and CMS/Census Bureau crosswalk (derived)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:** 2-character postal state code

- AK = Alaska
- AL = Alabama
- AR = Arkansas
- AZ = Arizona
- CA = California
- CO = Colorado
- CT = Connecticut
- DC = District of Columbia
- DE = Delaware
- FL = Florida
- GA = Georgia
- HI = Hawaii
- IA = Iowa
- ID = Idaho
- IL = Illinois
- IN = Indiana
- KS = Kansas
- KY = Kentucky
- LA = Louisiana
- MA = Massachusetts
- MD = Maryland
- ME = Maine
- MI = Michigan
- MN = Minnesota
- MO = Missouri
- MS = Mississippi
- MT = Montana
- NC = North Carolina
- ND = North Dakota
- NE = Nebraska
- NH = New Hampshire
- NJ = New Jersey
- NM = New Mexico
- NY = New York
- NV = Nevada
- OH = Ohio
- OK = Oklahoma
- OR = Oregon
- PA = Pennsylvania
- PR = Puerto Rico
- RI = Rhode Island
- SC = South Carolina
- SD = South Dakota
- TN = Tennessee
TX = Texas
UT = Utah
VA = Virginia
VI = Virgin Islands
VT = Vermont
WA = Washington
WI = Wisconsin
WV = West Virginia
WY = Wyoming
Null = Unknown

COMMENT: CCW derived this variable by taking the SSA state/county code on the CME record for that beneficiary in the CMS enrollment database and linking it to the corresponding state postal abbreviation. If we could not find a state using this method, we set the variable equal to the state portion of the beneficiary’s SSA state/county code. If that failed, we set the state equal to null.
**BENE_STATE_CD**

**LABEL:** Beneficiary Residence (SSA) State Code

**DESCRIPTION:** The social security administration (SSA) standard 2-digit state code of a beneficiary's residence.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:**

<table>
<thead>
<tr>
<th>Value</th>
<th>State</th>
</tr>
</thead>
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<tr>
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<td>unknown state</td>
</tr>
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</tr>
<tr>
<td>50</td>
<td>Washington</td>
</tr>
<tr>
<td>51</td>
<td>West Virginia</td>
</tr>
</tbody>
</table>

Medicare Encounter Records Codebook | 12 | May 2020
52 = Wisconsin 64 = American Samoa
53 = Wyoming 65 = Guam
57 = Central America and West 99 = With 000 county code is American
   Indies  Samoa;
60 = Oceania  Null/missing = unknown state
63 = U.S. Possessions

**COMMENT:** CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.
**CLM_1ST_DGNS_E_CD**

**LABEL:** First Claim Diagnosis E Code

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

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):**
- IP Base
- SNF Base
- HH Base
- OP Base

**VALUES:** -

**COMMENT:** On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

There are additional E code fields available in this file. The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).
**CLM_ADMSN_DT**

**LABEL:** Claim Admission Date

**DESCRIPTION:** On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or religious non-medical health care institution.

For home health services, this is the date care started for the HH services reported on the encounter record.

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base
HH Base

**VALUES:** -

**COMMENT:** For HH, this date indicates the date the home health plan was established or last reviewed.

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

**LABEL:** Billing Provider Zip Code

**DESCRIPTION:** This variable is the 9-digit zip code for the primary practice/business location of the physician receiving the payment or other transfer of value (i.e., the billing provider).

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base
             SNF Base
             HH Base
             OP Base
             Carrier Base
             DME Base

**VALUES:** 9-digit ZIP code (may have leading zeros)

**COMMENT:** -
<table>
<thead>
<tr>
<th><strong>CLM_BPRVDR_CITY_NAME</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
<td>Billing Provider Address - City</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>This variable is the billing provider city name, as submitted on the encounter.</td>
</tr>
<tr>
<td><strong>TYPE:</strong></td>
<td>CHAR</td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
<td>30</td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
<td>Medicare Advantage Organizations (MAOs)</td>
</tr>
<tr>
<td><strong>FILE(S):</strong></td>
<td>IP Base</td>
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<td>SNF Base</td>
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<td>HH Base</td>
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<td></td>
<td>Carrier Base</td>
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<tr>
<td></td>
<td>DME Base</td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
<td>-</td>
</tr>
</tbody>
</table>
**CLM_BPRVDR_USPS_STATE_CD**

**LABEL:** Billing Provider Address – USPS State Code

**DESCRIPTION:** This variable is the billing provider’s 2-character United States Postal Service (USPS) state code abbreviation, as submitted on the encounter.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):**
- IP Base
- SNF Base
- HH Base
- OP Base
- Carrier Base
- DME Base

**VALUES:**
- AK = Alaska
- AL = Alabama
- AR = Arkansas
- AZ = Arizona
- CA = California
- CO = Colorado
- CT = Connecticut
- DC = District of Columbia
- DE = Delaware
- FL = Florida
- GA = Georgia
- HI = Hawaii
- IA = Iowa
- ID = Idaho
- IL = Illinois
- IN = Indiana
- KS = Kansas
- KY = Kentucky
- LA = Louisiana
- MA = Massachusetts
- MD = Maryland
- ME = Maine
- MI = Michigan
- MN = Minnesota
- MO = Missouri
- MS = Mississippi
- MT = Montana
- NC = North Carolina
- ND = North Dakota
- NE = Nebraska
- NH = New Hampshire
- NJ = New Jersey
- NM = New Mexico
- NY = New York
- OH = Ohio
- OK = Oklahoma
- OR = Oregon
- PA = Pennsylvania
- PR = Puerto Rico
- RI = Rhode Island
- SC = South Carolina
- SD = South Dakota
- TN = Tennessee
- TX = Texas
- UT = Utah
- VA = Virginia
- VI = Virgin Islands
- VT = Vermont
- WA = Washington
- WI = Wisconsin
- WV = West Virginia
- WY = Wyoming
- XX = Unknown

**COMMENT:** -

[^ Back to TOC ^]
**CLM_CHRT_RVW_SW**

**LABEL:** Claim Chart Review Switch

**DESCRIPTION:** This variable is used to indicate whether the encounter record is a chart review record. Chart reviews are a type of encounter data record that allow Medicare Advantage Organizations (MAOs) to add or remove diagnoses that they identified through medical record reviews that were not initially reported on encounter data records.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:**

Y = Record is a chart review

Null/missing = Record is not a chart review

**COMMENT:** This is an indicator value that is set to ‘Y’ when MAOs report diagnoses obtained from medical record reviews (i.e., chart reviews) that were not initially reported on encounter data records when the MAO submitted the encounter. Otherwise, the value is set to null.

Chart review records may be submitted for any service type (including services that are not eligible for risk adjustment), and there are no limitations on the number of chart review records in totality or per encounter.

Additional details regarding the meaning and use of chart review records can be found in the Medicare Encounter Data User Guide.
**CLM_CNTL_NUM**

**LABEL:** Claim Control Number

**DESCRIPTION:** The claim control number is an identifier assigned by the processing system (i.e., the Encounter Data System Contractor) to a claim.

This is the field that, in combination with the original claim control number, identifies a unique version of a service record.

**TYPE:** CHAR

**LENGTH:** 23

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base
           SNF Base
           HH Base
           OP Base
           Carrier Base
           DME Base

**VALUES:** -

**COMMENT:** Multiple iterations of a single service (i.e., a particular type of claim for a specific service date for the person) are present in the Encounter RIFs; records are not limited to the final version of the encounter record. When multiple records for a service exist, the higher the claim control number, the later it was adjusted (i.e., the highest CLM_CNTL_NUM is the latest version of the encounter).
**CLM_DAY_CNT**

**LABEL:** Day Count (Length of Stay)

**DESCRIPTION:** This is a derived field that calculates the beneficiary's length of stay in an inpatient or SNF setting.

**TYPE:** NUM

**LENGTH:** 4

**SOURCE:** CMS Integrated Data Repository (IDR)

**FILE(S):** IP Base  
SNF Base

**VALUES:** -

**COMMENT:** The count of days is the (CLM_THRU_DT – CLM_FROM_DT)+1
**CLM_DRG_CD**

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

**DESCRIPTION:** The diagnostic related group to which a hospital claim belongs. A unique identifier of a hospital case type that is based on similar clinical problems.

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base

**VALUES:** -

**COMMENT:** This is an MAO submitted field and may be different than the derived DRG code (variable called DRVD_DRG_CD).

Nonpayment claims (zero reimbursement) may not have a DRG present.
Claim Diagnosis E Code I – 10 Diagnosis Present on Admission (POA) Indicator Code

The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary; fields ICD_DGNS_E_CD1-ICD_DGNS_E_CD10).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission. This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

CHAR
1

Medicare Advantage Organizations (MAOs)
Inpatient Base
SNF Base

Y = Diagnosis was present at the time of admission (POA)
N = Diagnosis was not present at the time of admission
U = Documentation is insufficient to determine if condition was present on admission
W = Provider is unable to clinically determine whether condition was present on admission

-
**CLM_FAC_TYPE_CD**

**LABEL:** Claim Facility Type Code  

**DESCRIPTION:** The type of facility.  

**TYPE:** CHAR  

**LENGTH:** 1  

**SOURCE:** Medicare Advantage Organizations (MAOs)  

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base  

**VALUES:**  
1 = Hospital  
2 = Skilled Nursing Facility (SNF)  
3 = Home Health Agency (HHA)  
4 = Religious Non-medical (hospital)  
7 = Clinic services or hospital-based renal dialysis facility  
8 = Ambulatory Surgery Center (ASC) or other special facility (e.g. hospice)  

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

The type of bill is the concatenation of two variables:  
- facility type (CLM_FAC_TYPE_CD)  
- service classification type (CLM_SRVC_CLSFCTN_TYPE_CD).  

Note that sometimes 3 variables are used for “type of bill”, where the 3rd digit is the claim frequency code (CLM_FREQ_CD).
**CLM_FINL_ACTN_IND**

**LABEL:** Claim Final Action Indicator

**DESCRIPTION:** This field is stored in the CMS Integrated Data Repository (IDR) as the final action indicator; however, CMS has verified that for 2015 encounter records, this field should not be used to identify the final version of the record. Note that the term “final action” is used differently in encounter data, compared to fee-for-service (FFS) claims.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** CMS Integrated Data Repository (IDR)

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base  
Carrier Base  
DME Base

**VALUES:**  
Y = Final action and the claim is not voided  
N = Subsequent adjustments to the claim exist or the final action was to void the claim

**COMMENT:** Duplicate services across multiple final action records may exist, and users should make appropriate adjustments when identifying distinct services. Additional information regarding identification of distinct services – or identification of populations appears in the Medicare Encounter Data User Guide.

Final action records are only indicative of the latest accepted record within a claim family that has been linked by the Medicare Advantage Organization (MAO) and may not be indicative of risk-adjustment eligibility.
**CLM_FREQ_CD**

**LABEL:** Claim Frequency Code

**DESCRIPTION:** The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base, SNF Base, HH Base, OP Base, Carrier Base, DME Base

**VALUES:**

0 = Non-payment/zero claims  
1 = Admit thru discharge claim  
2 = Interim – first claim  
3 = Interim – continuing claim  
4 = Interim – last claim  
5 = Late charge(s) only claim  
7 = Replacement of prior claim  
8 = Void/cancel prior claim  
9 = Final claim (for HH PPS = process as a debit/credit to RAP claim)  
A = Admission election notice (when hospice or Religious Nonmedical Health Care Institution is submitting the HCFA-1450 as an admission notice; this is to establish a hospice benefit period)  
G = Common Working File (NCH) generated adjustment claim  
H = CMS generated adjustment claim  
I = Misc. adjustment claim (e.g., initiated by intermediary or QIO)  
P = Adjustment required by QIO

**COMMENT:** This code is used for encounter final action processing for all encounter claim types, including carrier.
The encounter bill type frequency codes utilize a similar nomenclature to Medicare fee for service bill type frequency codes. This field can be used in determining the "type of bill" for an institutional claim. Often the type of bill consists of a combination of two variables: the facility type code (variable called CLM_FAC_TYPE_CD) and the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD).

This variable serves as the optional third component of bill type. Many different types of services can appear on an encounter institutional claim, and knowing the type of bill helps to distinguish them. The type of bill is the concatenation of three variables: the facility type (CLM_FAC_TYPE_CD), the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD), and the claim frequency code (CLM_FREQ_CD).

A 3-part type of bill is the concatenation of three variables:

- facility type (CLM_FAC_TYPE_CD)
- service classification type (CLM_SRVC_CLSFCTN_TYPE_CD)
- claim frequency code (CLM_FREQ_CD).
**CLM_FROM_DT**

**LABEL:** Claim From Date

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

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
            SNF Base
            HH Base
            OP Base
            Carrier Base
            DME Base

**VALUES:** -

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

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

**LABEL:** Claim Inpatient Admission Type Code

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

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base

**VALUES:**

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

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

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

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

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

9 = Unknown - Information not available.

**COMMENT:** -
**CLM_LINE_NUM**

**LABEL:** Claim Line Number

**DESCRIPTION:** This variable identifies an individual line number on an encounter record claim. Each revenue center record or claim line has a sequential line number to distinguish distinct services that are submitted on the same encounter record. All revenue center records or claim lines on a given claim have the same encounter join key (variable called ENC_JOIN_KEY).

**TYPE:** NUM

**LENGTH:** 13

**SOURCE:** CCW

**FILE(S):** IP Revenue  
SNF Revenue  
HH Revenue  
OP Revenue  
Carrier Line  
DME Line

**VALUES:** -

**COMMENT:** Note that the original claim line number from the CMS Integrated Data Repository (IDR) is also included in these data files (variable called LINE_NUM_ORIG), for the benefit of CMS.
**CLM_LTST_CLM_IND**

**LABEL:** Latest Claim Indicator

**DESCRIPTION:** This variable indicates if the record is the latest action.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** CMS Integrated Data Repository (IDR)

**FILE(S):**
- IP Base
- SNF Base
- HH Base
- OP Base
- Carrier Base
- DME Base

**VALUES:**
- Y = Latest action and the record could be a chart review
- N = Subsequent adjustments or resubmissions to the claim exist
- Null/missing = not latest record

**COMMENT:** -
**CLM_MDCL_REC**

**LABEL:** Claim Medical Record Number

**DESCRIPTION:** The number assigned by the provider to the beneficiary's medical record to assist in record retrieval. The medical record number has special significance for chart review encounters. When the chart review’s purpose is to delete a diagnosis code from the claim, the medical record number should be ‘8’.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:** 8 = MAO is deleting the diagnoses on the record.
Null/missing

**COMMENT:** This variable may be null/missing. No values other than 8 are in this field.
**CLM_OBSLT_DT**

**LABEL:** Claim Obsolete Date

**DESCRIPTION:** The date the claim is no longer the latest action (including chart reviews that link to an original claim).

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** CMS Integrated Data Repository (IDR)

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base  
Carrier Base  
DME Base

**VALUES:** -

**COMMENT:** Note that the CLM_OBSLT_DT='12-31-9999' for claims without any subsequent adjustments. When the record is superseded by subsequent adjustments, then the CLM_OBSLT_DT=(EDPS_CREATE_DT of the record with the latest action – 1).
**CLM_ORIG_CNTL_NUM**

**LABEL:** Claim Original Control Number

**DESCRIPTION:** This variable is the original intermediary control number (ICN) which is present on adjustment encounter, representing the ICN of the original transaction now being adjusted.

**TYPE:** CHAR

**LENGTH:** 23

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):**
- IP Base
- SNF Base
- HH Base
- OP Base
- Carrier Base
- DME Base

**VALUES:** -

**COMMENT:** When an encounter record has been adjusted, the claim control number (CLM_CNTL_NUM) for the version of the record that is being adjusted appears in the CLM_ORIG_CNTL_NUM field – and then a new CLM_CNTL_NUM is assigned to this updated record. A null/missing CLM_ORIG_CNTL_NUM indicates that a prior encounter record has not been adjusted by the Medicare Advantage Organization (MAO). Generally, this implies that it is the first occurrence of an encounter service record, but occasionally, multiple record submissions for the same service may appear as original encounters.
**CLM_PLACE_OF_SRVC_CD**

**LABEL:** Claim Place of Service Code

**DESCRIPTION:** The code indicating where the service was performed; the place of service.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** Carrier Base
DME Base

**VALUES:**

00 = Unknown

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

02 = Unassigned. N/A

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

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

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

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

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

08 = Tribal 638 Provider-based Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09</td>
<td>Prison/Correctional Facility. A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.</td>
</tr>
<tr>
<td>10</td>
<td>Unassigned. N/A</td>
</tr>
<tr>
<td>11</td>
<td>Office. Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</td>
</tr>
<tr>
<td>12</td>
<td>Home. Location, other than a hospital or other facility, where the patient receives care in a private residence.</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility. Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.</td>
</tr>
<tr>
<td>14</td>
<td>Group Home. A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit. A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.</td>
</tr>
<tr>
<td>16</td>
<td>Temporary Lodging. A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.</td>
</tr>
<tr>
<td>17</td>
<td>Walk-in Retail Health Clinic. A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.</td>
</tr>
<tr>
<td>18</td>
<td>Place of employment/worksite</td>
</tr>
<tr>
<td>19</td>
<td>Off campus – outpatient hospital</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility. Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital. A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.</td>
</tr>
</tbody>
</table>
22 = Outpatient Hospital. A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

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

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

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

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

27 = Unassigned. N/A

28 = Unassigned. N/A

29 = Unassigned. N/A

30 = Unassigned. N/A

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

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

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

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

35-40 = Unassigned. N/A

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

43-48 = Unassigned. N/A

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

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

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

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

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

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

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

56 = Psychiatric Residential Treatment Center. A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57 = Non-residential Substance Abuse Treatment Facility. A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

58 = Unassigned. N/A

59 = Unassigned. N/A

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

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

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

63 = Unassigned. N/A

64 = Unassigned. N/A

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

66-70 = Unassigned. N/A

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

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

73-80 = Unassigned. N/A

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

82-98 = Unassigned. N/A
99 = Other Place of Service. Other place of service not identified above.

0D = Unknown

0O = Unknown

C0 = Unknown

CC = Unknown

DW = Unknown

JC = Unknown

N0 = Unknown

N4 = Unknown

NS = Unknown

N6 = Unknown

ND = Unknown

P0 = Unknown

SE = Unknown

XY = Unknown

ZZ = Unknown

COMMENT: Values and websites referenced in the Variable Value Description may change over time.

LABEL: Claim Diagnosis Code I – 25 Diagnosis Present on Admission (POA) Indicator Code

DESCRIPTION: The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary; which are the ICD_DGNS_CD1-ICD_DGNS_CD25 fields).

In response to the Deficit Reduction Act of 2005, CMS began to distinguish between hospitalization diagnoses that occurred prior to versus during the admission. The
objective was to eventually not pay hospitals more if the patient acquired a condition (e.g., infection) during the admission.

This present on admission (POA) field is used to indicate whether the diagnosis was present on admission.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base

**VALUES:**
- **Y =** Diagnosis was present at the time of admission (POA)
- **N =** Diagnosis was not present at the time of admission
- **U =** Documentation is insufficient to determine if condition was present on admission
- **W =** Provider is unable to clinically determine whether condition was present on admission

**COMMENT:** The present on admission indicators for the diagnosis E codes are stored in CLM_E_POA_IND_SW1 - CLM_E_POA_IND_SW10.
CLM_RCPT_DT

**LABEL:** Claim Receipt Date

**DESCRIPTION:** The date the encounter was submitted into the CMS Encounter Data System (EDS).

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:** -

**COMMENT:** It is the transaction control number associated with the date the batch of encounter records was submitted. This date will be equal to or less than the EDPS_CREATE_DT.
**CLM_RLT_COND_CD**

**LABEL:** Claim Related Condition Code

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

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Condition Code File  
SNF Condition Code File  
HH Condition Code File  
OP Condition Code File

**VALUES:**

01 THRU 16 = Insurance related

17 THRU 30 = Special condition

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

36 THRU 45 = Accommodation

46 THRU 54 = CHAMPUS information

55 THRU 59 = Skilled nursing facility

60 THRU 70 = Prospective payment

71 THRU 99 = Renal dialysis setting

A0 THRU B9 = Special program codes

C0 THRU C9 = QIO approval services

D0 THRU W0 = Change conditions

===========================================

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

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

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

04 = Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Hospital must also expect to receive payment from HMO.
05 = Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.

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

07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.

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

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

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

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

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

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

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

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

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

17 = Patient is homeless.

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

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

20 = Beneficiary requested billing - Provider realizes the services on this bill are at a non-covered level of care or otherwise excluded from coverage, but the bene has requested formal determination.
21 = Billing for denial notice - The SNF or HHA realizes services are at a non-covered level of care or excluded, but requests a Medicare denial in order to bill Medicaid or other insurer

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

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

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

25 = Reserved for national assignment

26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility

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

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

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

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

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

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

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

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

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

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

38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
39 = Private room medically necessary - Patient needed a private room for medical reasons.

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

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

42 = Continuing Care Not Related to Inpatient Admission - continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services.

43 = Continuing Care Not Provided Within Prescribed Post-discharge Window - continuing care was related to the inpatient admission but the prescribed care was not provided within the post-discharge window.

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

45 = Reserved for national assignment.

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

47 = Reserved for TRICARE.

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

49 = Product Replacement within Product Lifecycle - replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement.

51 = Reserved for national assignment.

52 = Reserved for national assignment.

53 = Reserved for national assignment.

54 = Reserved for national assignment.

55 = SNF bed not available - The patient’s SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56 = Medical appropriateness - Patient’s SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period

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

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

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

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

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

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

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

64 = Other than clean claim - The claim is not a ‘clean claim’

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

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

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

68 = Beneficiary elects to use LTR days

69 = IME/DGME/N&A Payment Only - providers request for request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health).

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

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

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

73 = Self-care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>74</td>
<td>Home - Billing is for a patient who received dialysis services at home.</td>
</tr>
<tr>
<td>75</td>
<td>Home dialysis patient using a dialysis machine that was purchased under the 100% program.</td>
</tr>
<tr>
<td>76</td>
<td>Back-up in facility dialysis - Billing is for a patient who received dialysis services in a back-up facility.</td>
</tr>
<tr>
<td>77</td>
<td>Provider accepts or is obligated/required due to contractual agreement or law to accept payment by the primary payer as payment in full - no Medicare payment is due.</td>
</tr>
<tr>
<td>78</td>
<td>New coverage not implemented by HMO, indicates newly covered service under Medicare for which HMO does not pay.</td>
</tr>
<tr>
<td>79</td>
<td>CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.</td>
</tr>
<tr>
<td>80</td>
<td>Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility.</td>
</tr>
<tr>
<td>81-99</td>
<td>Reserved for state assignment.</td>
</tr>
<tr>
<td>A0</td>
<td>Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance.</td>
</tr>
<tr>
<td>A1</td>
<td>EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code.</td>
</tr>
<tr>
<td>A2</td>
<td>Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped.</td>
</tr>
<tr>
<td>A3</td>
<td>Special federal funding - Designed for uniform use by state uniform billing committees. Special program indicator code.</td>
</tr>
<tr>
<td>A4</td>
<td>Family planning - Designed for uniform use by state uniform billing committees. Special program indicator code.</td>
</tr>
<tr>
<td>A5</td>
<td>Disability - Designed for uniform use by state uniform billing committees.</td>
</tr>
<tr>
<td>A6</td>
<td>PPV/Medicare - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.</td>
</tr>
<tr>
<td>A7</td>
<td>Induced abortion to avoid danger to woman's life.</td>
</tr>
<tr>
<td>A8</td>
<td>Induced abortion - Victim of rape/incest. Special program indicator code.</td>
</tr>
<tr>
<td>A9</td>
<td>Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>AA</td>
<td>Abortion Performed due to Rape</td>
</tr>
<tr>
<td>AB</td>
<td>Abortion Performed due to Incest</td>
</tr>
<tr>
<td>AC</td>
<td>Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality</td>
</tr>
<tr>
<td>AD</td>
<td>Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or exacerbated by the Pregnancy itself</td>
</tr>
<tr>
<td>AE</td>
<td>Abortion Performed due to physical health of mother that is not life endangering</td>
</tr>
<tr>
<td>AF</td>
<td>Abortion performed due to emotional/psychological health of mother</td>
</tr>
<tr>
<td>AG</td>
<td>Abortion performed due to social economic reasons</td>
</tr>
<tr>
<td>AH</td>
<td>Elective Abortion</td>
</tr>
<tr>
<td>AI</td>
<td>Sterilization</td>
</tr>
<tr>
<td>AJ</td>
<td>Payer Responsible for copayment</td>
</tr>
<tr>
<td>AK</td>
<td>Air Ambulance Required - For ambulance claims. Time needed to transport poses a threat.</td>
</tr>
<tr>
<td>AL</td>
<td>Specialized Treatment/bed Unavailable - For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility.</td>
</tr>
<tr>
<td>AM</td>
<td>Non-emergency Medically Necessary Stretcher Transport Required - For ambulance claims. Non-emergency medically necessary stretcher transport required.</td>
</tr>
<tr>
<td>AN</td>
<td>Preadmission Screening Not Required – person meets the criteria for an exemption from preadmission screening.</td>
</tr>
<tr>
<td>B0</td>
<td>Medicare Coordinated Care Demonstration Program - patient is a participant in a Medicare Coordinated Care Demonstration</td>
</tr>
<tr>
<td>B1</td>
<td>Beneficiary ineligible for demonstration program</td>
</tr>
<tr>
<td>B2</td>
<td>Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule</td>
</tr>
<tr>
<td>B3</td>
<td>Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law.</td>
</tr>
<tr>
<td>B4</td>
<td>Admission Unrelated to Discharge – Admission unrelated to discharge on same day.</td>
</tr>
<tr>
<td>B5</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
<tr>
<td>B6</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
</tbody>
</table>
B7 = Special program indicator Reserved for national assignment.
B8 = Special program indicator Reserved for national assignment.
B9 = Special program indicator Reserved for national assignment.
C0 = Reserved for national assignment.
C1 = Approved as billed - Claim has been reviewed by the QIO and has been fully approved including any outlier.
C2 = QIO approval indicator services. NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C3 = Partial approval - some portion (days or services). From/Through dates of the approved portion of the stay are shown as code “M0” in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code “77” in FL 36 or code “46” in FL 39-41).
C4 = Admission denied - The patient’s need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary.
C5 = Post-payment review applicable - Any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6 = Preadmission/Pre-procedure authorization - The QIO authorized this admission/procedure but has not reviewed the services provided.
C7 = Extended authorization - The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
C8 = Reserved for national assignment. QIO approval indicator services
C9 = Reserved for national assignment. QIO approval indicator services
D0 = Changes to service dates.
D1 = Changes in charges.
D2 = Changes in revenue codes/HCPCS/HIPPS Rate Code - Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
D3 = Second or subsequent interim PPS bill.
D4 = Change in ICD-9-CM diagnosis and/or procedure code
D5 = Cancel only to correct a beneficiary claim account number (HICN) or provider identification number.
D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill).

D7 = Change to make Medicare the secondary payer.

D8 = Change to make Medicare the primary payer.

D9 = Any other change.

DR = Disaster Relief - Code used to facilitate claims processing and track services/items provided to victims of disasters.

E0 = Change in patient status.

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

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

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

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

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

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

MA = GI Bleed.

MB = Pneumonia.

MC = Pericarditis.

MD = Myelodysplastic Syndrome.

ME = Hereditary Hemolytic and Sickle Cell Anemia.

MF = Monoclonal Gammopathy.

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

XX = Transgender/Hermaphrodite Beneficiaries

COMMENT: -
**CLM_RLT_OCRNC_CD**

**LABEL:** Claim Related Occurrence Code

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

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

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Occurrence Code File  
SNF Occurrence Code File  
HH Occurrence Code File  
OP Occurrence Code File

**VALUES:**

- 01 THRU 09 = Accident
- 10 THRU 19 = Medical condition
- 20 THRU 39 = Insurance related
- 40 THRU 69 = Service related
- A1 - A3 = Miscellaneous

01 = Auto accident - The date of an auto accident.
02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04 = Accident/employment related - The date of an accident relating to the patient's employment.
05 = Other accident - The date of an accident not described by the codes 01 thru 04.
06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07 = Reserved for national assignment.
08 = Reserved for national assignment.
11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.
13 = Reserved for national assignment.
14 = Reserved for national assignment.
15 = Reserved for national assignment.
16 = Reserved for national assignment.
17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed.
18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.
19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21 = UR notice received - Code indicating the date of receipt by the hospital & SNF of the UR committee's finding that the admission or future stay was not medically necessary.
22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23 = Cancellation of Hospice benefits - The date the RHHI cancelled the hospice benefit. (eff. 10/00). NOTE: this will be different than the revocation of the hospice benefit by beneficiaries.
24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.
25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.
26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27 = Date of Hospice Certification or Re-Certification -- code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/01)

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

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

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

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

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

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

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

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

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

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

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

38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.
39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.

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

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

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

43 = Scheduled Date of Canceled Surgery - date which ambulatory surgery was scheduled.

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

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

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

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

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

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

50-69 = Reserved for state assignment

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

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

A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A.
B1 = Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried.

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

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

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

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

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

COMMENT: -
CLM_RLT_OCRNC_DT

**LABEL:** Claim Related Occurrence Date

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

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

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Occurrence Code File  
SNF Occurrence Code File  
HH Occurrence Code File  
OP Occurrence Code File

**VALUES:** -

**COMMENT:** -
**CLM_SPAN_CD**

**LABEL:** Claim Occurrence Span Code

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

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

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Span Code File
SNF Span Code File
HH Span Code File
OP Span Code File

**VALUES:**

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

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

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

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

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

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

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

- **77 =** Provider liability (utilization charged) – The from/thru dates of period of non-covered care for which the provider is liable. Applies to provider liability where bene is charged with utilization and is liable for deductible/coinsurance
78 = SNF prior stay dates – The from/thru dates of any SNF stay that ended within 60
days of this hospital or SNF admission.

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

80-99 = Reserved for state assignment

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

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

M2 = Dates of Inpatient Respite Care – from/thru dates of a period of inpatient
respite care for hospice patients.

COMMENT: -
**CLM_SPAN_FROM_DT**

**LABEL:** Claim Occurrence Span From Date

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

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

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Span Code File
SNF Span Code File
HH Span Code File
OP Span Code File

**VALUES:** -

**COMMENT:** -
**CLM_SPAN_THRU_DT**

**LABEL:** Claim Occurrence Span Through Date

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

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

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Span Code File  
SNF Span Code File  
HH Span Code File  
OP Span Code File

**VALUES:** -

**COMMENT:** -
**CLM_SRC_IP_ADMSN_CD**

**LABEL:** Claim Source Inpatient Admission Code

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

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base

**VALUES:**

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

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

3 = HMO referral – The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.

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

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

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

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

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

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

A = Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
B = Transfer from Another Home Health Agency – The patient was admitted to this home health agency as a transfer from another home health agency. (Discontinued July 1, 2010- See Condition Code 47)

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

E = Transfer from Ambulatory Surgical Center

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

Null/missing = unknown

For Newborn Type of Admission

1 = Normal delivery – A baby delivered without complications.

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

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

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

5 = Reserved for national assignment.

6 = Reserved for national assignment.

7 = Reserved for national assignment.

8 = Reserved for national assignment.

9 = Information not available.
**CLM_SRVC_CLSFCTN_TYPE_CD**

**LABEL:** Claim Service Classification Type Code

**DESCRIPTION:** The type of service provided to the beneficiary.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base

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

1 = Inpatient
2 = Inpatient or Home Health (covered on Part B)
3 = Outpatient (or HHA - covered on Part A)
4 = Other (Part B) -- (Includes HHA medical and other health services, e.g., SNF osteoporosis-injectable drugs)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (revenue code 019X required) (formerly Intermediate care - level III)
8 = Swing bed

For facility type code 7 (clinics):

1 = Rural Health Clinic (RHC)
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center (FQHC)
4 = Other Rehabilitation Facility (ORF)
5 = Comprehensive Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC)
7 = Federally Qualified Health Center (FQHC)
9 = Other

For facility type code 8 (special facility):


1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center (ASC) in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital - Outpatient Services
9 = Other

**COMMENT:** This field, in combination with the facility type code (variable called CLM_FAC_TYPE_CD) indicates the “type of bill” for an institutional claim. Many different types of services can appear on an institutional encounter record, and knowing the type of bill helps to distinguish them. The type of bill is the concatenation of two variables: the facility type (CLM_FAC_TYPE_CD) and the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD).
**CLM_SUBSCR_ADR_ZIP_CD**

**LABEL:** Medicare Subscriber Address – ZIP Code

**DESCRIPTION:** This field represents the subscriber’s mailing ZIP code. It is the zip 5 and 4-digit extension as submitted on the encounter record.

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:** -

**COMMENT:** -
**CLM_SUBSCR_CITY_NAME**

**LABEL:** Medicare Subscriber Address – City

**DESCRIPTION:** This variable is the Medicare subscriber’s city name, as submitted on the encounter record.

**TYPE:** CHAR

**LENGTH:** 30

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
- SNF Base
- HH Base
- OP Base
- Carrier Base
- DME Base

**VALUES:** -

**COMMENT:** -
**CLM_SUBSCR_USPS_STATE_CD**

**LABEL:** Medicare Subscriber Address – USPS State Code

**DESCRIPTION:** This variable is the Medicare subscriber’s 2-character United States Postal Service (USPS) state code abbreviation, as submitted on the encounter record.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

**VALUES:**

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</table>

COMMENT: -
**CLM_THRU_DT**

**LABEL:** Claim Through Date

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

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** All Encounter Files

**VALUES:** -

**COMMENT:** The "thru" date on the claim may not always represent the last date of services, particularly for Home Health or Hospice care. To obtain the date corresponding with the cessation of services (or discharge date) use the discharge date from the encounter (variable called BENE_DSCHRG_DT).

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

**LABEL:** Claim Type Code

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

**TYPE:** CHAR

**LENGTH:** 4

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** All files – every base/revenue/line/trailer

**VALUES:**

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<th>Encounter File</th>
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<th>Description</th>
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<td>Religious Nonmedical Health Care Institutions - Hospital Inpatient</td>
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<td></td>
<td>4074 =</td>
<td>Clinic (ORF) Outpatient Rehab Facility</td>
</tr>
<tr>
<td></td>
<td>4075 =</td>
<td>Clinic (CORF) Comprehensive Outpatient Rehab Facility</td>
</tr>
<tr>
<td></td>
<td>4076 =</td>
<td>Clinic (CMHC) Community Mental Health Centers</td>
</tr>
<tr>
<td></td>
<td>4077 =</td>
<td>Clinic (FQHC) Federal Qualified Health Center</td>
</tr>
<tr>
<td></td>
<td>4079 =</td>
<td>Clinic - Other</td>
</tr>
<tr>
<td></td>
<td>4083 =</td>
<td>Special Facility (ASC) Ambulatory Surgery Center</td>
</tr>
<tr>
<td></td>
<td>4085 =</td>
<td>Special Facility (CAH) Critical Access Hospital</td>
</tr>
<tr>
<td></td>
<td>4089 =</td>
<td>Special Facility - Other</td>
</tr>
<tr>
<td>Encounter File</td>
<td>CLM_TYPE_CD</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Carrier</td>
<td>4700 =</td>
<td>Professional</td>
</tr>
<tr>
<td>DME</td>
<td>4800 =</td>
<td>DME</td>
</tr>
</tbody>
</table>

COMMENT: -
**CLM_VAL_CD**

**LABEL:** Claim Value Code

**DESCRIPTION:** The code indicating a monetary condition which was used on an institutional claim.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):**
- IP Value Code File
- SNF Value Code File
- HH Value Code File
- OP Value Code File

**VALUES:**
- 01 = Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
- 02 = Hospital Has No Semi-Private Rooms - Entering this code requires $0.00 amount.
- 04 = Inpatient professional component charges which are combined billed - For use only by some all-inclusive rate hospitals.
- 05 = Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
- 06 = Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
- 08 = Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission.
- 09 = Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission.
- 10 = Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
- 11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years.
- 12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
- 13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment.</td>
</tr>
<tr>
<td>15</td>
<td>That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.</td>
</tr>
<tr>
<td>16</td>
<td>That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.</td>
</tr>
<tr>
<td>17</td>
<td>Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry).</td>
</tr>
<tr>
<td>18</td>
<td>Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry).</td>
</tr>
<tr>
<td>19</td>
<td>Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry).</td>
</tr>
<tr>
<td>21</td>
<td>Catastrophic - Medicaid - Eligibility requirements to be determined at state level.</td>
</tr>
<tr>
<td>22</td>
<td>Surplus - Medicaid - Eligibility requirements to be determined at state level.</td>
</tr>
<tr>
<td>23</td>
<td>Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level.</td>
</tr>
<tr>
<td>24</td>
<td>Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level.</td>
</tr>
<tr>
<td>25</td>
<td>Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).</td>
</tr>
<tr>
<td>26</td>
<td>Prescription Drugs Offset to Patient (Payment Amount - Hearing and Ear Services) Hearing and ear services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement covers period).</td>
</tr>
<tr>
<td>27</td>
<td>Offset to the Patient (Payment Amount - Vision and Eye Services) - Vision and eye services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).</td>
</tr>
<tr>
<td>28</td>
<td>Offset to the Patient (Payment Amount - Dental Services) - Dental services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).</td>
</tr>
</tbody>
</table>
29 = Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropractic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).

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

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

32 = Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination.

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

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

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

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

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

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

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

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

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

43 = Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.
44 = Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due.

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

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

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

48 = Hemoglobin reading - The patient's most recent hemoglobin reading taken before the start of the billing period

49 = Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period

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

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

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

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

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

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

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

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

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

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

61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider. The value code amount field reflects the CBSA code.

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

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

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

69 = State charity Care Percent – code indicates the percentage of charity care eligibility for the patient.

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

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

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

80 = Covered Days - the number of days covered by the primary payer as qualified by the payer.

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

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

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

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

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

91-99 = Reserved for state assignment.

A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance.
A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (eff. 10/93) - Prior value 07

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

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

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

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

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

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

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

AA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer.

AB = Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer.

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

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

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

C3 = Estimated Responsibility Payer C
CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).

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

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

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

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

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

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

Y3 = Part B coinsurance - Amount of Part B coinsurance for this demonstration project claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

COMMENT: -
**CNTRCT_NUM**

**LABEL:** Medicare Part C Contract Number

**DESCRIPTION:** This variable is the unique identification for a managed care organization (MCO) enabling the entity to provide coverage to eligible Medicare beneficiaries.

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base  
Carrier Base  
DME Base

**VALUES:** 5-digit alphanumeric

**COMMENT:** The first character of the contract ID is a letter that indicates the type of plan. For local managed care contracts, it begins with 'H' or '9'; for regional managed care contracts, it begins with 'R'; for prescription drug plans (PDPs), it begins with 'S'; for fallback contracts, it begins with 'F', for Employer-Direct PDP and Employer-Direct PFFS it begins with 'E'. The remaining 4 digits are numeric.

You need to know both the contract number and plan benefit package number (CNTRCT_PBP_NUM) in order to identify the specific plan in which a beneficiary was enrolled.
CNTRCT_PBP_NUM

LABEL:  Medicare Part C Plan Benefit Package (PBP) Number

DESCRIPTION:  The variable is the plan benefit package (PBP) number for the beneficiary’s managed care plan. CMS assigns an identifier to each PBP within a contract that a plan sponsor has with CMS.

TYPE:  CHAR

LENGTH:  3

SOURCE:  CMS Encounter Data System (EDS)

FILE(S):  IP Base
          SNF Base
          HH Base
          OP Base
          Carrier Base
          DME Base

VALUES:  3-digit numeric

COMMENT:  You need to know both the contract number (variable called CNTRCT_NUM) and plan benefit package number (plan ID) in order to identify the specific plan in which a beneficiary was enrolled. CNTRCT_PBP_NUM is not submitted by the MAO on an encounter data record; the MAO only submits the contract ID. Instead the plan ID is assigned by CMS based on the beneficiary’s enrollment data for the claim dates of service. CMS enrollment data is obtained from the source CMS Common Medicare Environment (CME) data.

^ Back to TOC ^
**DOB_DT**

**LABEL:** Date of Birth from Encounter

**DESCRIPTION:** The beneficiary's date of birth, as recorded on the encounter record

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** CMS Common Medicare Environment (CME)

**FILE(S):** IP Base
             SNF Base
             HH Base
             Carrier Base
             DME Base

**VALUES:** -

**COMMENT:** -
**DRVD_DRG_CD**

**LABEL:** Derived MS-Diagnosis Related Group Code (MS-DRG)

**DESCRIPTION:** The Medicare Severity diagnostic related group (MS-DRG) to which a hospital claim belongs for prospective payment purposes that is derived by the Encounter Data Processing System (EDPS).

**TYPE:** CHAR

**LENGTH:** 4

**SOURCE:** Encounter Data System (EDS)

**FILE(S):** IP Base
SNF Base

**VALUES:** -

**COMMENT:** This element is returned from 3M. It is calculated based on the diagnoses, procedures, age, sex, discharge status on an encounter record.
**EDPS_CREATE_DT**

**LABEL:** Encounter Data Processing System (EDPS) Create Date

**DESCRIPTION:** The date that an encounter record was created on the CMS Encounter Data Processing System (EDPS) database.

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** IP Base, SNF Base, HH Base, OP Base, Carrier Base, DME Base

**VALUES:** -

**COMMENT:** The CLM_RCPT_DT is derived from the claim control number created by the CMS Encounter Data System, and it will typically be equal to or less than the EDPS_CREATN_DT.
**ENC_JOIN_KEY**

**LABEL:** Unique encounter join key

**DESCRIPTION:** This is a unique join key assigned by CCW/CMS to assist the user in joining the base claim to a line claim for each encounter record.

**TYPE:** CHAR

**LENGTH:** 15

**SOURCE:** CCW

**FILE(S):** All Encounter Files

**VALUES:** -

**COMMENT:** Each IP, SNF, HH or OP Encounter base record has at least one revenue center record. Each Carrier or DME Encounter base record has at least one line record. All revenue center records or lines on a given encounter record have the same ENC_JOIN_KEY. It is used to link the revenue lines together and/or to the base claim.
**GNDR_CD**

**LABEL:** Gender Code from Encounter record

**DESCRIPTION:** The sex of a beneficiary.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** CMS Common Medicare Environment (CME)

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base  
Carrier Base  
DME Base

**VALUES:**

- 0 = Unknown
- 1 = Male
- 2 = Female

**COMMENT:** -
HCPCS_1ST_MDFR_CD

HCPCS_2ND_MDFR_CD

HCPCS_3RD_MDFR_CD

HCPCS_4TH_MDFR_CD

**LABEL:**  HCPCS Modifier Code

**DESCRIPTION:**  Modifiers 1 - 4 to the Healthcare Common Procedure Coding System (HCPCS) procedure code to enable a more specific procedure identification for the revenue center or line item service for the encounter record.

**TYPE:**  CHAR

**LENGTH:**  2

**SOURCE:**  Medicare Advantage Organizations (MAOs)

**FILE(S):**  IP Revenue  
SNF Revenue  
HH Revenue  
OP Revenue  
Carrier Line  
DME Line

**VALUES:**  -

**COMMENT:**  -
**HCPCS_CD**

**LABEL:** Healthcare Common Procedure Coding System (HCPCS) Code

**DESCRIPTION:** The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below (in COMMENT).

In the Institutional Encounter Revenue Center Files, this variable can indicate the specific case-mix grouping that Medicare used to pay for skilled nursing facility (SNF), home health, or inpatient rehabilitation facility (IRF) services (see Note 2 in COMMENT section below).

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Revenue  
SNF Revenue  
HH Revenue  
OP Revenue  
Carrier Line  
DME Line

**VALUES:** -

**COMMENT:** Level I


**** Note 1: ****

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

Level II

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

Level III

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

**** Note 2: ****

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

This field will contain a HIPPS code if the revenue center code (REV_CNTR) equals 0022 for SNF care, 0023 for home health, or 0024 for IRF care.
LABEL: Claim Diagnosis Code 1-25

DESCRIPTION: The diagnosis code identifying the beneficiary's diagnosis. There are up to 25 diagnosis codes for IP, SNF, HH and OP claims, and up to 13 diagnosis codes on the carrier and DME claims. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).

TYPE: CHAR
LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base
         SNF Base
         HH Base
         OP Base
         Carrier Base
         DME Base

VALUES: -

COMMENT: On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.
ICD_DGNS_E_CD1
ICD_DGNS_E_CD2
ICD_DGNS_E_CD3
ICD_DGNS_E_CD4
ICD_DGNS_E_CD5
ICD_DGNS_E_CD6
ICD_DGNS_E_CD7
ICD_DGNS_E_CD8
ICD_DGNS_E_CD9
ICD_DGNS_E_CD10

LABEL: Claim Diagnosis E Code 1-10

DESCRIPTION: The code used to identify an external cause of injury, poisoning, or other adverse effect. The lower the number in the variable name, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_E_CD1 is considered more important than ICD_DGNS_E_CD9).

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base
        SNF Base
        HH Base
        OP Base

VALUES: -

COMMENT: On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.
ICD_DGNS_VRSN_CD1
ICD_DGNS_VRSN_CD2
ICD_DGNS_VRSN_CD3
ICD_DGNS_VRSN_CD4
ICD_DGNS_VRSN_CD5
ICD_DGNS_VRSN_CD6
ICD_DGNS_VRSN_CD7
ICD_DGNS_VRSN_CD8
ICD_DGNS_VRSN_CD9
ICD_DGNS_VRSN_CD10
ICD_DGNS_VRSN_CD11
ICD_DGNS_VRSN_CD12
ICD_DGNS_VRSN_CD13

LABEL: Claim Diagnosis Code 1-13 Diagnosis Version Code (ICD-9 or ICD-10)

DESCRIPTION: Effective with Version 'J', the code used to indicate if the diagnosis code (for the ICD_DGNS_CD1-13 fields) is ICD-9 or ICD-10.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Base
DME Base

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

COMMENT: On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. ICD-10 has more than 70,000 unique diagnosis codes compared to approximately 14,000 ICD-9 codes, which allows for more detail surrounding diagnoses.

The diagnosis version code applies to all diagnoses on the claim (i.e., diagnoses appear in variables ICD_DGNS_CDX).

This field is not present in the institutional claims (inpatient, skilled nursing, home health) since the cutover occurred exactly on October 1, 2015. Although this cutover date applies to carrier/DME claims, there are some instances where a billing date could straddle the cutoff date (e.g., DME ordered vs. received dates), therefore we include this field to enable verification as to which codes are used.
ICD_PRCDR_CD1
ICD_PRCDR_CD2
ICD_PRCDR_CD3
ICD_PRCDR_CD4
ICD_PRCDR_CD5
ICD_PRCDR_CD6
ICD_PRCDR_CD7
ICD_PRCDR_CD8
ICD_PRCDR_CD9
ICD_PRCDR_CD10
ICD_PRCDR_CD11
ICD_PRCDR_CD12
ICD_PRCDR_CD13

LABEL: Claim Procedure Code 1-13

DESCRIPTION: The code that indicates the procedure(s) performed during the period covered by the institutional claim. There are up to 13 procedures on the claim. The principal procedure is recorded in ICD_PRCDR_CD1, and secondary, tertiary, etc. procedures are in ICD_PRCDR_CD2-13.

TYPE: CHAR
LENGTH: 7
SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base
    SNF Base
    OP Base

VALUES: -

COMMENT: The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. For inpatient and skilled nursing claims, health care providers use the International Classification of Diseases version 9 (ICD-9) procedure codes to describe the service provided. Starting in October 2015, the ICD-10 Procedure Coding System (ICD-10-PCS), is used.

HCPCS/CPT codes were named as the standard code set for physician services and other health care services.
LINE_1ST_EXPNS_DT

LABEL: Line First Expense Date

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

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line
DME Line

VALUES: -

COMMENT: -
<table>
<thead>
<tr>
<th>FIELD</th>
<th>LABEL</th>
<th>DESCRIPTION</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>SOURCE</th>
<th>FILE(S)</th>
<th>VALUES</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINE_LAST_EXPNS_DT</td>
<td>Line Last Expense Date</td>
<td>The ending date (last expense) for the line item service on the non-institutional encounter record.</td>
<td>DATE</td>
<td>8</td>
<td>Medicare Advantage Organizations (MAOs)</td>
<td>Carrier Line, DME Line</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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

**LABEL:** Line Latest Claim Indicator

**DESCRIPTION:** Indicates if the line on the encounter record is the latest action.

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** CMS Integrated Data Repository (IDR)

**FILE(S):** IP Revenue  
SNF Revenue  
HH Revenue  
OP Revenue  
Carrier Line  
DME Line

**VALUES:**  
Y = Latest action and the record could be a chart review  
N = Subsequent adjustments or resubmissions to the claim line exist.

**COMMENT:** -
**LINE_NDC_CD**

**LABEL:** Line National Drug Code (NDC)

**DESCRIPTION:** This field is the National Drug Code (NDC) identifying the specific drug.

**TYPE:** CHAR

**LENGTH:** 11

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** Carrier Line
DME Line

**VALUES:** -

**COMMENT:** -
LINE_NUM_ORIG

LABEL: Original Claim Line Number

DESCRIPTION: This variable identifies an individual line number on an encounter record claim, as assigned in the CMS Integrated Data Repository (IDR).

TYPE: NUM

LENGTH: 13

SOURCE: CCW

FILE(S): IP Revenue
        SNF Revenue
        HH Revenue
        OP Revenue
        Carrier Line
        DME Line

VALUES: -

COMMENT: This field is included for the benefit of CMS users who wish to trace the encounter records in the IDR.

Note that this original claim line number may differ from the claim line number (CLM_LINE_NUM), which is a sequential line number on the CCW Encounter RIF to distinguish distinct services that are submitted on the same encounter record.
**LINE_PLACE_OF_SRVC_CD**

**LABEL:** Line Place of Service Code

**DESCRIPTION:** The code indicating where the service was performed; the place of service.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** Carrier Line  
DME Line

**VALUES:**  
00 = Unknown  
01 = Pharmacy. A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.  
02 = Unassigned. N/A  
03 = School. A facility whose primary purpose is education.  
04 = Homeless Shelter. A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).  
05 = Indian Health Service - Free-standing Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.  
06 = Indian Health Service - Provider-based Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.  
07 = Tribal 638 - Free-standing Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.  
08 = Tribal 638 Provider-based Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic
Admitted as inpatients or outpatients.

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

10 = Unassigned. N/A

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

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

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

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

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

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

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

18 = Place of employment/worksite

19 = Off campus – outpatient hospital

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

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

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

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

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

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

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

27 = Unassigned. N/A

29 = Unassigned. N/A

30 = Unassigned. N/A

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

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

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

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

35-40 = Unassigned. N/A

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

43-48 = Unassigned. N/A

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

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

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

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

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

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

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

56 = Psychiatric Residential Treatment Center. A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57 = Non-residential Substance Abuse Treatment Facility. A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

58 = Unassigned. N/A

59 = Unassigned. N/A

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

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

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

63 = Unassigned. N/A

64 = Unassigned. N/A

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

66-70 = Unassigned. N/A

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

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

73-80 = Unassigned. N/A

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

82-98 = Unassigned. N/A
99 = Other Place of Service. Other place of service not identified above.

0D = Unknown
0O = Unknown
C0 = Unknown
CC = Unknown
DW = Unknown
JC = Unknown
N0 = Unknown
N4 = Unknown
NS = Unknown
N6 = Unknown
ND = Unknown
P0 = Unknown
SE = Unknown
XY = Unknown
ZZ = Unknown

COMMENT: Values and websites referenced in the Variable Value Description may change over time.

**LINE_RX_NUM**

**LABEL:** Carrier Line RX Number

**DESCRIPTION:** The pharmacy's internal invoice number on pharmaceutical claims.

**TYPE:** CHAR

**LENGTH:** 30

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** Carrier Line

**VALUES:** -

**COMMENT:** -
**LINE_SRVC_CNT**

**LABEL:** Line Service Count

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

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** CMS Encounter Data System (EDS)

**FILE(S):** Carrier Line
DME Line

**VALUES:** 0 – XXXX (numeric values may include decimals)

**COMMENT:** -

^ Back to TOC ^
**OP_PHYSN_NPI**

**LABEL:** Claim Operating Physician NPI Number

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

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):**
- IP Base
- SNF Base
- HH Base
- OP Base

**VALUES:** -

**COMMENT:** -
ORG_NPI

LABEL: Organization NPI Number

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

For a non-institutional claim or encounter record, this is the NPI number of the billing provider on the claim.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base
         SNF Base
         HH Base
         OP Base
         Carrier Base
         DME Base

VALUES: -

COMMENT: -
ORG_TXNMY_CD

LABEL: Organization Taxonomy Code

DESCRIPTION: This variable is the health care provider taxonomy (HCPT) code used to indicate the billing provider’s specialty. This is a unique identifier for a classification of health care specialty at a specialized level of defined medical activity within a medical field as created by the National Uniform Claim Committee (NUCC).

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base
SNF Base
HH Base
OP Base
Carrier Base
DME Base

VALUES: -

**OT_PHYSN_NPI**

**LABEL:** Claim Other Physician NPI Number

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

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base  
SNF Base  
HH Base  
OP Base

**VALUES:** -

**COMMENT:** There are additional physician identifiers on the encounter record, including the attending physician (AT_PHYSN_NPI) and, depending on the claim type, the operating physician (OP_PHYSN_NPI), rendering physician (RNDRNG_PHYSN_NPI) or referring physician (RFRG_PHYSN_NPI).
PRCDR_DT1
PRCDR_DT2
PRCDR_DT3
PRCDR_DT4
PRCDR_DT5
PRCDR_DT6
PRCDR_DT7
PRCDR_DT8
PRCDR_DT9
PRCDR_DT10
PRCDR_DT11
PRCDR_DT12
PRCDR_DT13

LABEL: Claim Procedure Code 1-13 Date
DESCRIPTION: The date on which the procedure was performed. The date associated with the procedure identified in ICD_PRCDR_CD1-ICD_PRCDR_CD13.
TYPE: DATE
LENGTH: 8
SOURCE: Medicare Advantage Organizations (MAOs)
FILE(S): IP Base
          SNF Base
          OP Base
VALUES: -
COMMENT: -
### PRNCPAL_DGNS_CD

**LABEL:** Claim Principal Diagnosis Code  

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

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

**TYPE:** CHAR  

**LENGTH:** 7  

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base, SNF Base, HH Base, OP Base, Carrier Base, DME Base

**VALUES:** -  

**COMMENT:** -
**PRNPCAL_DGNS_VRSN_CD**

**LABEL:** Claim Principal Diagnosis Version Code

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

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** Carrier Base  
DME Base

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

**COMMENT:** With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10.

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

LABEL: Line Rendering Physician NPI

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

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line
          DME Line

VALUES: -

COMMENT: -
**PRVDR_SPCLTY**

**LABEL:** Line CMS Provider Specialty Code

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

Assigned by the Medicare Advantage Organization (MAO) based on the corresponding provider identification number (performing NPI).

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** Carrier Line
DME Line

**VALUES:**
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech / language pathology
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
20 = Orthopedic surgery
22 = Pathology
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = General Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometrist
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA)
44 = Infectious disease
46 = Endocrinology
48 = Podiatry
50 = Nurse practitioner
62 = Psychologist (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist (private practice)
66 = Rheumatology
67 = Occupational therapist (private practice)
68 = Clinical psychologist
72 = Pain Management
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
97 = Physician assistant
98 = Gynecologist/oncologist
99 = Unknown physician specialty

COMMENT: -
PTNT_DSCHRG_STUS_CD

**LABEL:** Patient Discharge Status Code

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

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Base
               SNF Base

**VALUES:**
- 0 = Unknown Value (but present in data)
- 01 = Discharged to home/self-care (routine charge).
- 02 = Discharged/transferred to other short term general hospital for inpatient care.
- 03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care.
- 04 = Discharged/transferred to intermediate care facility (ICF).
- 05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
- 06 = Discharged/transferred to home care of organized home health service organization.
- 07 = Left against medical advice or discontinued care.
- 09 = Admitted as an inpatient to this hospital. In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
- 20 = Expired (patient did not recover).
- 21 = Discharged/transferred to court/law enforcement.
- 30 = Still patient.
- 40 = Expired at home (hospice)
- 41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
- 42 = Expired - place unknown -this is used only on Medicare and TRICARE claims for Hospice only
- 43 = Discharged/transferred to a federal hospital
- 50 = Discharged/transferred to a Hospice – home.
51 = Discharged/transferred to a Hospice – medical facility.
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital.
63 = Discharged/transferred to a long term care hospitals.
64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare
65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital.
66 = Discharged/transferred to a Critical Access Hospital (CAH)
69 = Discharged/transferred to a designated disaster alternative care site (applies only to particular MS-DRGs*)
70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (discontinued effective 10/1/05)

The following codes apply only to particular MS-DRGs*, and were new in 10/2013:
81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission.
82 = Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission.
83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission.
84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.
85 = Discharged/transferred to a designated cancer center or children’s hospital with a planned acute care hospital inpatient readmission.
86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.
87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.
88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission.
89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.
90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.

91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.

92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.

93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.

94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.

95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

**COMMENT:** * MS-DRG codes where additional codes were available are:

280 (Acute Myocardial Infarction, Discharged Alive with MCC),

281 (Acute Myocardial Infarction, Discharged Alive with CC),

282 (Acute Myocardial Infarction, Discharged Alive without CC/MCC), and

789 (Neonates, Died or Transferred to Another Acute Care Facility).
REV_CNTR

LABEL: Revenue Center Code

DESCRIPTION: The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary).

A cost center is a division or unit within a hospital (e.g. radiology, emergency room, pathology).

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

TYPE: CHAR

LENGTH: 4

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue
        SNF Revenue
        HH Revenue
        OP Revenue

VALUES: 0001 = Total charge

        0022 = SNF encounter. This code may appear multiple times on an encounter to identify different HIPPS Rate Code/assessment periods.

        0023 = Home Health services. This code may appear multiple times on an encounter to identify different HIPPS/Home Health Resource Groups (HRG).

        0024 = Inpatient Rehabilitation Facility services.

        0100 = All-inclusive rate - room and board plus ancillary

        0101 = All-inclusive rate - room and board

        0110 = Private medical or general - general classification

        0111 = Private medical or general - medical/surgical/GYN

        0112 = Private medical or general - OB

        0113 = Private medical or general - pediatric

        0114 = Private medical or general - psychiatric

        0115 = Private medical or general - hospice

        0116 = Private medical or general - detoxification

        0117 = Private medical or general - oncology
0118 = Private medical or general - rehabilitation
0119 = Private medical or general - other
0120 = Semi-private 2 bed (medical or general) general classification
0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
0122 = Semi-private 2 bed (medical or general) - OB
0123 = Semi-private 2 bed (medical or general) - pediatric
0124 = Semi-private 2 bed (medical or general) - psychiatric
0125 = Semi-private 2 bed (medical or general) - hospice
0126 = Semi-private 2 bed (medical or general) - detoxification
0127 = Semi-private 2 bed (medical or general) - oncology
0128 = Semi-private 2 bed (medical or general) - rehabilitation
0129 = Semi-private 2 bed (medical or general) - other
0130 = Semi-private 3 and 4 beds - general classification
0131 = Semi-private 3 and 4 beds - medical/surgical/GYN
0132 = Semi-private 3 and 4 beds - OB
0133 = Semi-private 3 and 4 beds - pediatric
0134 = Semi-private 3 and 4 beds - psychiatric
0135 = Semi-private 3 and 4 beds - hospice
0136 = Semi-private 3 and 4 beds - detoxification
0137 = Semi-private 3 and 4 beds - oncology
0138 = Semi-private 3 and 4 beds - rehabilitation
0139 = Semi-private 3 and 4 beds - other
0140 = Private (deluxe) - general classification
0141 = Private (deluxe) - medical/surgical/GYN
0142 = Private (deluxe) - OB
0143 = Private (deluxe) - pediatric
0144 = Private (deluxe) - psychiatric
0145 = Private (deluxe) - hospice
0146 = Private (deluxe) - detoxification
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>0147</td>
<td>Private (deluxe) - oncology</td>
</tr>
<tr>
<td>0148</td>
<td>Private (deluxe) - rehabilitation</td>
</tr>
<tr>
<td>0149</td>
<td>Private (deluxe) - other</td>
</tr>
<tr>
<td>0150</td>
<td>Room &amp; Board ward (medical or general) - general classification</td>
</tr>
<tr>
<td>0151</td>
<td>Room &amp; Board ward (medical or general) - medical/surgical/GYN</td>
</tr>
<tr>
<td>0152</td>
<td>Room &amp; Board ward (medical or general) - OB</td>
</tr>
<tr>
<td>0153</td>
<td>Room &amp; Board ward (medical or general) - pediatric</td>
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<tr>
<td>0154</td>
<td>Room &amp; Board ward (medical or general) - psychiatric</td>
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<td>0155</td>
<td>Room &amp; Board ward (medical or general) - hospice</td>
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<td>0156</td>
<td>Room &amp; Board ward (medical or general) - detoxification</td>
</tr>
<tr>
<td>0157</td>
<td>Room &amp; Board ward (medical or general) - oncology</td>
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<td>0158</td>
<td>Room &amp; Board ward (medical or general) - rehabilitation</td>
</tr>
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<td>0159</td>
<td>Room &amp; Board ward (medical or general) - other</td>
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<td>0160</td>
<td>Other Room &amp; Board - general classification</td>
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<td>0164</td>
<td>Other Room &amp; Board - sterile environment</td>
</tr>
<tr>
<td>0167</td>
<td>Other Room &amp; Board - self care</td>
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<tr>
<td>0169</td>
<td>Other Room &amp; Board - other</td>
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<tr>
<td>0170</td>
<td>Nursery - general classification</td>
</tr>
<tr>
<td>0171</td>
<td>Nursery - newborn level I (routine)</td>
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<tr>
<td>0172</td>
<td>Nursery - premature newborn - level II (continuing care)</td>
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<td>0173</td>
<td>Nursery - newborn-level III (intermediate care)</td>
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<tr>
<td>0174</td>
<td>Nursery - newborn-level IV (intensive care)</td>
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<td>0179</td>
<td>Nursery - other</td>
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<tr>
<td>0180</td>
<td>Leave of absence - general classification</td>
</tr>
<tr>
<td>0182</td>
<td>Leave of absence - patient convenience charges billable</td>
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<tr>
<td>0183</td>
<td>Leave of absence - therapeutic leave</td>
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<tr>
<td>0184</td>
<td>Leave of absence - ICF mentally retarded - any reason</td>
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<tr>
<td>0185</td>
<td>Leave of absence - nursing home (hospitalization)</td>
</tr>
<tr>
<td>0189</td>
<td>Leave of absence - other leave of absence</td>
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</tbody>
</table>
0190 =  Subacute care - general classification
0191 =  Subacute care - level I
0192 =  Subacute care - level II
0193 =  Subacute care - level III
0194 =  Subacute care - level IV
0199 =  Subacute care - other
0200 =  Intensive care - general classification
0201 =  Intensive care - surgical
0202 =  Intensive care - medical
0203 =  Intensive care - pediatric
0204 =  Intensive care - psychiatric
0206 =  Intensive care - post ICU; redefined as intermediate ICU
0207 =  Intensive care - burn care
0208 =  Intensive care - trauma
0209 =  Intensive care - other intensive care
0210 =  Coronary care - general classification
0211 =  Coronary care - myocardial infraction
0212 =  Coronary care - pulmonary care
0213 =  Coronary care - heart transplant
0214 =  Coronary care - post CCU; redefined as intermediate CCU
0219 =  Coronary care - other coronary care
0220 =  Special charges - general classification
0221 =  Special charges - admission charge
0222 =  Special charges - technical support charge
0223 =  Special charges - UR service charge
0224 =  Special charges - late discharge, medically necessary
0229 =  Special charges - other special charges
0230 =  Incremental nursing charge rate - general classification
0231 =  Incremental nursing charge rate - nursery
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<tr>
<td>0232</td>
<td>Incremental nursing charge rate - OB</td>
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<td>Incremental nursing charge rate - ICU</td>
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<td>0234</td>
<td>Incremental nursing charge rate - CCU</td>
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<td>0235</td>
<td>Incremental nursing charge rate - hospice</td>
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<td>0239</td>
<td>Incremental nursing charge rate - other</td>
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<td>0240</td>
<td>All-inclusive ancillary - general classification</td>
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<td>0241</td>
<td>All-inclusive ancillary - basic</td>
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<td>0242</td>
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<td>0243</td>
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<td>All-inclusive ancillary - other inclusive ancillary</td>
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<td>Pharmacy-general classification</td>
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<td>0251</td>
<td>Pharmacy-generic drugs</td>
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<td>0252</td>
<td>Pharmacy-nongeneric drugs</td>
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<td>0253</td>
<td>Pharmacy-take home drugs</td>
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<td>0254</td>
<td>Pharmacy-drugs incident to other diagnostic service-subject to payment limit</td>
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<td>Pharmacy-drugs incident to radiology-subject to payment limit</td>
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<td>Pharmacy-experimental drugs</td>
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<td>Pharmacy-non-prescription</td>
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<td>Pharmacy-IV solutions</td>
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<td>0259</td>
<td>Pharmacy-other pharmacy</td>
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<td>IV therapy-general classification</td>
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<td>0261</td>
<td>IV therapy-infusion pump</td>
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<td>IV therapy-pharmacy services</td>
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<td>0263</td>
<td>IV therapy-drug supply/delivery</td>
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<td>0264</td>
<td>IV therapy-supplies</td>
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<td>0269</td>
<td>IV therapy-other IV therapy</td>
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<td>0270</td>
<td>Medical/surgical supplies - general classification</td>
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<td>Medical/surgical supplies - nonsterile supply</td>
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<td>0272</td>
<td>Medical/surgical supplies - sterile supply</td>
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<td>Code</td>
<td>Description</td>
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<td>Medical/surgical supplies - take home supplies</td>
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<td>Medical/surgical supplies - prosthetic/orthotic devices</td>
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<td>Medical/surgical supplies - pace maker</td>
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<td>0276</td>
<td>Medical/surgical supplies - intraocular lens</td>
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<td>Medical/surgical supplies - oxygen-take home</td>
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<td>Medical/surgical supplies - other implants</td>
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<td>Medical/surgical supplies - other devices</td>
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<td>Oncology-general classification</td>
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<td>Oncology-other oncology</td>
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<td>0290</td>
<td>DME (other than renal) - general classification</td>
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<td>0291</td>
<td>DME (other than renal) - rental</td>
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<td>0292</td>
<td>DME (other than renal) - purchase of new DME</td>
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<td>0293</td>
<td>DME (other than renal) - purchase of used DME</td>
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<td>0294</td>
<td>DME (other than renal) - related to and listed as DME</td>
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<td>DME (other than renal) - other</td>
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<td>0301</td>
<td>Laboratory - chemistry</td>
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<td>0302</td>
<td>Laboratory - immunology</td>
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<td>Laboratory - renal patient (home)</td>
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<td>Laboratory - non-routine dialysis</td>
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<td>0305</td>
<td>Laboratory - hematology</td>
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<td>Laboratory - bacteriology &amp; microbiology</td>
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<td>Laboratory - urology</td>
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<td>Laboratory - other laboratory</td>
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<td>Laboratory pathological - general classification</td>
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<td>0311</td>
<td>Laboratory pathological - cytology</td>
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<td>Laboratory pathological - histology</td>
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<td>Laboratory pathological - biopsy</td>
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</table>
0320 = Radiology diagnostic - general classification
0321 = Radiology diagnostic - angiocardiography
0322 = Radiology diagnostic - arthrography
0323 = Radiology diagnostic - arteriography
0324 = Radiology diagnostic - chest X-ray
0329 = Radiology diagnostic - other
0330 = Radiology therapeutic - general classification
0331 = Radiology therapeutic - chemotherapy injected
0332 = Radiology therapeutic - chemotherapy oral
0333 = Radiology therapeutic - radiation therapy
0335 = Radiology therapeutic - chemotherapy IV
0339 = Radiology therapeutic - other
0340 = Nuclear medicine - general classification
0341 = Nuclear medicine - diagnostic
0342 = Nuclear medicine - therapeutic
0343 = Nuclear medicine-diagnostic radiopharmaceuticals
0344 = Nuclear medicine-therapeutic radiopharmaceuticals
0349 = Nuclear medicine - other
0350 = Computed tomographic (CT) scan-general classification
0351 = CT scan - head scan
0352 = CT scan - body scan
0359 = CT scan - other CT scans
0360 = Operating room services - general classification
0361 = Operating room services - minor surgery
0362 = Operating room services - organ transplant, other than kidney
0367 = Operating room services - kidney transplant
0369 = Operating room services - other operating room services
0370 = Anesthesia - general classification
0371 = Anesthesia - incident to RAD and subject to the payment limit
0372 = Anesthesia - incident to other diagnostic service and subject to the payment limit
0374 = Anesthesia - acupuncture
0379 = Anesthesia - other anesthesia
0380 = Blood - general classification
0381 = Blood - packed red cells
0382 = Blood - whole blood
0383 = Blood - plasma
0384 = Blood - platelets
0385 = Blood - leukocytes
0386 = Blood - other components
0387 = Blood - other derivatives (cryoprecipitates)
0389 = Blood - other blood
0390 = Blood storage and processing - general classification
0391 = Blood storage and processing - blood administration
0392 = Blood storage and processing – storage and processing
0399 = Blood storage and processing - other
0400 = Other imaging services - general classification
0401 = Other imaging services - diagnostic mammography
0402 = Other imaging services - ultrasound
0403 = Other imaging services - screening mammography
0404 = Other imaging services - positron emission tomography
0409 = Other imaging services - other
0410 = Respiratory services - general classification
0412 = Respiratory services - inhalation services
0413 = Respiratory services - hyperbaric oxygen therapy
0419 = Respiratory services - other
0420 = Physical therapy - general classification
0421 = Physical therapy - visit charge
0422 = Physical therapy - hourly charge
0423 = Physical therapy - group rate
0424 = Physical therapy - evaluation or re-evaluation
0429 = Physical therapy - other
0430 = Occupational therapy - general classification
0431 = Occupational therapy - visit charge
0432 = Occupational therapy - hourly charge
0433 = Occupational therapy - group rate
0434 = Occupational therapy - evaluation or re-evaluation
0439 = Occupational therapy - other (may include restorative therapy)
0440 = Speech language pathology - general classification
0441 = Speech language pathology - visit charge
0442 = Speech language pathology - hourly charge
0443 = Speech language pathology - group rate
0444 = Speech language pathology - evaluation or re-evaluation
0449 = Speech language pathology - other
0450 = Emergency room - general classification
0451 = Emergency room - EMTALA emergency medical screening services
0452 = Emergency room - ER beyond EMTALA screening
0456 = Emergency room - urgent care
0459 = Emergency room - other
0460 = Pulmonary function - general classification
0469 = Pulmonary function - other
0470 = Audiology - general classification
0471 = Audiology - diagnostic
0472 = Audiology - treatment
0479 = Audiology - other
0480 = Cardiology - general classification
0481 = Cardiology - cardiac cath lab
0482 = Cardiology - stress test
0483 = Cardiology - Echocardiology
0489 = Cardiology - other
0490 = Ambulatory surgical care - general classification
0499 = Ambulatory surgical care - other
0500 = Outpatient services - general classification
0509 = Outpatient services - other
0510 = Clinic - general classification
0511 = Clinic - chronic pain center
0512 = Clinic - dental center
0513 = Clinic - psychiatric
0514 = Clinic - OB-GYN
0515 = Clinic - pediatric
0516 = Clinic - urgent care clinic
0517 = Clinic - family practice clinic
0519 = Clinic - other
0520 = Free-standing clinic - general classification
0521 = Free-standing clinic - clinic visit by a member to RHC/FQHC
0522 = Free-standing clinic - home visit by RHC/FQHC practitioner
0523 = Free-standing clinic - family practice
0524 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0526 = Free-standing clinic - urgent care
0527 = Free-standing clinic - RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area
0528 = Free-standing clinic - visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g. scene of accident)
0529 = Free-standing clinic - other
0530 = Osteopathic services - general classification
0531 = Osteopathic services - osteopathic therapy
0539 = Osteopathic services - other
0540 = Ambulance - general classification
0541 = Ambulance - supplies
0542 = Ambulance - medical transport
0543 = Ambulance - heart mobile
0544 = Ambulance - oxygen
0545 = Ambulance - air ambulance
0546 = Ambulance - neo-natal ambulance
0547 = Ambulance - pharmacy
0548 = Ambulance - telephone transmission EKG
0549 = Ambulance - other
0550 = Skilled nursing-general classification
0551 = Skilled nursing-visit charge
0552 = Skilled nursing-hourly charge
0559 = Skilled nursing-other
0560 = Medical social services-general classification
0561 = Medical social services-visit charge
0562 = Medical social services-hourly charges
0569 = Medical social services-other
0570 = Home health aid (home health) - general classification
0571 = Home health aid (home health) - visit charge
0572 = Home health aid (home health) - hourly charge
0579 = Home health aid (home health) - other
0580 = Other visits (home health) - general classification (under HHPPS, not allowed as covered charges)
0581 = Other visits (home health) - visit charge (under HHPPS, not allowed as covered charges)
0582 = Other visits (home health) - hourly charge (under HHPPS, not allowed as covered charges)

0589 = Other visits (home health) - other (under HHPPS, not allowed as covered charges)

0590 = Units of service (home health) - general classification (under HHPPS, not allowed as covered charges)

0599 = Units of service (home health) - other (under HHPPS, not allowed as covered charges)

0600 = Oxygen/Home Health-general classification

0601 = Oxygen/Home Health-stat or port equip/supply or count

0602 = Oxygen/Home Health-stat/equip/under 1 LPM

0603 = Oxygen/Home Health-stat/equip/over 4 LPM

0604 = Oxygen/Home Health-stat/equip/portable add-on

0610 = Magnetic resonance technology (MRT)-general classification

0611 = MRT/MRI-brain (including brainstem)

0612 = MRT/MRI-spinal cord (including spine)

0614 = MRT/MRI-other

0615 = MRT/MRA-Head and Neck

0616 = MRT/MRA-Lower Extremities

0618 = MRT/MRA-other

0619 = MRT/Other MRI

0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit - extension of 027X

0622 = Medical/surgical supplies-incident to other diagnostic service - subject to the payment limit - extension of 027X

0623 = Medical/surgical supplies-surgical dressings - extension of 027X

0624 = Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE's - extension of 027X

0630 = Reserved

0631 = Drugs requiring specific identification - single drug source

0632 = Drugs requiring specific identification - multiple drug source
0633 = Drugs requiring specific identification - restrictive prescription
0634 = Drugs requiring specific identification - EPO under 10,000 units
0635 = Drugs requiring specific identification - EPO 10,000 units or more
0636 = Drugs requiring specific identification - detailed coding
0637 = Self-administered drugs administered in an emergency situation - not requiring detailed coding
0640 = Home IV therapy - general classification
0641 = Home IV therapy - nonroutine nursing
0642 = Home IV therapy - IV site care, central line
0643 = Home IV therapy - IV start/change peripheral line
0644 = Home IV therapy - nonroutine nursing, peripheral line
0645 = Home IV therapy - train patient/caregiver, central line
0646 = Home IV therapy - train disabled patient, central line
0647 = Home IV therapy - train patient/caregiver, peripheral line
0648 = Home IV therapy - train disabled patient, peripheral line
0649 = Home IV therapy - other IV therapy services
0650 = Hospice services - general classification
0651 = Hospice services - routine home care
0652 = Hospice services - continuous home care - 1/2
0655 = Hospice services - inpatient care
0656 = Hospice services - general inpatient care (non-respite)
0657 = Hospice services - physician services
0659 = Hospice services - other
0660 = Respite care (HHA) - general classification
0661 = Respite care (HHA) - hourly charge/skilled nursing
0662 = Respite care (HHA) - hourly charge/home health aide/homemaker
0670 = OP special residence charges - general classification
0671 = OP special residence charges - hospital based
0672 = OP special residence charges - contracted
0679 = OP special residence charges - other special residence charges
0681 = Trauma response-Level I Trauma
0682 = Trauma response-Level II Trauma
0683 = Trauma response-Level III Trauma
0684 = Trauma response-Level IV Trauma
0689 = Trauma response-Other trauma response
0690 = Pre-hospice/Palliative Care Services - general (eff. 7/1/17)
0691 = Pre-hospice/Palliative Care Services - visit (eff. 7/1/17)
0692 = Pre-hospice/Palliative Care Services - hourly (eff. 7/1/17)
0693 = Pre-hospice/Palliative Care Services - evaluation (eff. 7/1/17)
0694 = Pre-hospice/Palliative Care Services - consultation & education (eff. 7/1/17)
0695 = Pre-hospice/Palliative Care Services - Inpatient (eff. 7/1/17)
0696 = Pre-hospice/Palliative Care Services - Physician (eff. 7/1/17)
0699 = Pre-hospice/Palliative Care Services - Other (eff. 7/1/17)
0700 = Cast room - general classification
0709 = Cast room - other
0710 = Recovery room - general classification
0719 = Recovery room - other
0720 = Labor room/delivery - general classification
0721 = Labor room/delivery - labor
0722 = Labor room/delivery - delivery
0723 = Labor room/delivery - circumcision
0724 = Labor room/delivery - birthing center
0729 = Labor room/delivery - other
0730 = EKG/ECG - general classification
0731 = EKG/ECG - Holter monitor
0732 = EKG/ECG - telemetry
0739 = EKG/ECG - other
0740 = EEG - general classification
0749 = EEG (electroencephalogram) - other
0750 = Gastro-intestinal services - general classification
0759 = Gastro-intestinal services - other
0760 = Treatment or observation room - general classification
0761 = Treatment or observation room - treatment room
0762 = Treatment or observation room - observation room
0769 = Treatment or observation room - other
0770 = Preventative care services - general classification
0771 = Preventative care services - vaccine administration
0779 = Preventative care services - other
0780 = Telemedicine - general classification
0789 = Telemedicine - telemedicine
0790 = Lithotripsy - general classification
0799 = Lithotripsy - other
0800 = Inpatient renal dialysis - general classification
0801 = Inpatient renal dialysis - inpatient hemodialysis
0802 = Inpatient renal dialysis - inpatient peritoneal (non-CAPD)
0803 = Inpatient renal dialysis - inpatient CAPD
0804 = Inpatient renal dialysis - inpatient CCPD
0809 = Inpatient renal dialysis - other inpatient dialysis
0810 = Organ acquisition - general classification
0811 = Organ acquisition - living donor
0812 = Organ acquisition - cadaver donor
0813 = Organ acquisition - unknown donor
0814 = Organ acquisition - unsuccessful organ search - donor bank charges
0815 = Allogeneic Stem Cell Acquisition/Donor Services
0819 = Organ acquisition - other donor
0820 = Hemodialysis OP or home dialysis - general classification
0821 = Hemodialysis OP or home dialysis - hemodialysis - composite or other rate
0822 = Hemodialysis OP or home dialysis - home supplies
0823 = Hemodialysis OP or home dialysis - home equipment
0824 = Hemodialysis OP or home dialysis - maintenance/100%
0825 = Hemodialysis OP or home dialysis - support services
0829 = Hemodialysis OP or home dialysis - other
0830 = Peritoneal dialysis OP or home - general classification
0831 = Peritoneal dialysis OP or home - peritoneal - composite or other rate
0832 = Peritoneal dialysis OP or home - home supplies
0833 = Peritoneal dialysis OP or home - home equipment
0834 = Peritoneal dialysis OP or home - maintenance/100%
0835 = Peritoneal dialysis OP or home - support services
0839 = Peritoneal dialysis OP or home - other
0840 = CAPD outpatient - general classification
0841 = CAPD outpatient - CAPD/composite or other rate
0842 = CAPD outpatient - home supplies
0843 = CAPD outpatient - home equipment
0844 = CAPD outpatient - maintenance/100%
0845 = CAPD outpatient - support services
0849 = CAPD outpatient - other
0850 = CCPD outpatient - general classification
0851 = CCPD outpatient - CCPD/composite or other rate
0852 = CCPD outpatient - home supplies
0853 = CCPD outpatient - home equipment
0854 = CCPD outpatient - maintenance/100%
0855 = CCPD outpatient - support services
0859 = CCPD outpatient – other
0860 = Magnetoencephalography (MEG) - general classification
0861 = Magnetoencephalography (MEG) - MEG
0880 = Miscellaneous dialysis - general classification
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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>0881</td>
<td>Miscellaneous dialysis - ultrafiltration</td>
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<td>0882</td>
<td>Miscellaneous dialysis - home dialysis aide visit</td>
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<tr>
<td>0889</td>
<td>Miscellaneous dialysis - other</td>
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<td>0890</td>
<td>Other donor bank - general classification; changed to reserved for national assignment</td>
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<tr>
<td>0891</td>
<td>Other donor bank - bone; changed to reserved for national assignment</td>
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<td>0892</td>
<td>Other donor bank - organ (other than kidney); changed to reserved for national assignment</td>
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<td>0893</td>
<td>Other donor bank - skin; changed to reserved for national assignment</td>
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<td>Other donor bank - other; changed to reserved for national assignment</td>
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<td>Behavior Health Treatment/Services - general classification</td>
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<td>0901</td>
<td>Behavior Health Treatment/Services - electroshock treatment</td>
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<td>0902</td>
<td>Behavior Health Treatment/Services - milieu therapy</td>
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<td>0903</td>
<td>Behavior Health Treatment/Services - play therapy</td>
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<td>Behavior Health Treatment/Services - activity therapy</td>
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<td>Behavior Health Treatment/Services - intensive outpatient services-psychiatric</td>
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<td>Behavior Health Treatment/Services - intensive outpatient services-chemical dependency</td>
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<td>0907</td>
<td>Behavior Health Treatment/Services - community behavioral health program-day treatment</td>
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<td>Reserved for National Use</td>
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<td>0910</td>
<td>Behavioral Health Treatment/Services - Reserved for National Assignment</td>
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<td>Behavioral Health Treatment/Services - rehabilitation</td>
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<td>0912</td>
<td>Behavioral Health Treatment/Services - partial hospitalization - less intensive</td>
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<td>0913</td>
<td>Behavioral Health Treatment/Services - partial hospitalization - intensive</td>
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<td>0914</td>
<td>Behavioral Health Treatment/Services - individual therapy</td>
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<td>0915</td>
<td>Behavioral Health Treatment/Services - group therapy</td>
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<td>Behavioral Health Treatment/Services - family therapy</td>
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<td>0917</td>
<td>Behavioral Health Treatment/Services - biofeedback</td>
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<tr>
<td>0918</td>
<td>Behavioral Health Treatment/Services - testing</td>
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</tbody>
</table>
0919 = Behavioral Health Treatment/Services - other
0920 = Other diagnostic services - general classification
0921 = Other diagnostic services - peripheral vascular lab
0922 = Other diagnostic services - electromyelogram
0923 = Other diagnostic services - pap smear
0924 = Other diagnostic services - allergy test
0925 = Other diagnostic services - pregnancy test
0929 = Other diagnostic services - other
0931 = Medical Rehabilitation Day Program - Half Day
0932 = Medical Rehabilitation Day Program - Full Day
0940 = Other therapeutic services - general classification
0941 = Other therapeutic services - recreational therapy
0942 = Other therapeutic services - education/training (include diabetes diet training)
0943 = Other therapeutic services - cardiac rehabilitation
0944 = Other therapeutic services - drug rehabilitation
0945 = Other therapeutic services - alcohol rehabilitation
0946 = Other therapeutic services - routine complex medical equipment
0947 = Other therapeutic services - ancillary complex medical equipment
0948 = Other therapeutic services - pulmonary rehab
0949 = Other therapeutic services - other
0951 = Professional Fees - athletic training (extension of 094X)
0952 = Professional Fees - kinesiotherapy (extension of 094X)
0960 = Professional fees - general classification
0961 = Professional fees - psychiatric
0962 = Professional fees - ophthalmology
0963 = Professional fees - anesthesiologist (MD)
0964 = Professional fees - anesthetist (CRNA)
0969 = Professional fees - other (NOTE: 097X is an extension of 096X)
0971 = Professional fees - laboratory
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0972</td>
<td>Professional fees - radiology diagnostic</td>
</tr>
<tr>
<td>0973</td>
<td>Professional fees - radiology therapeutic</td>
</tr>
<tr>
<td>0974</td>
<td>Professional fees - nuclear medicine</td>
</tr>
<tr>
<td>0975</td>
<td>Professional fees - operating room</td>
</tr>
<tr>
<td>0976</td>
<td>Professional fees - respiratory therapy</td>
</tr>
<tr>
<td>0977</td>
<td>Professional fees - physical therapy</td>
</tr>
<tr>
<td>0978</td>
<td>Professional fees - occupational therapy</td>
</tr>
<tr>
<td>0979</td>
<td>Professional fees - speech pathology (NOTE: 098X is an extension of 096X &amp; 097X)</td>
</tr>
<tr>
<td>0981</td>
<td>Professional fees - emergency room</td>
</tr>
<tr>
<td>0982</td>
<td>Professional fees - outpatient services</td>
</tr>
<tr>
<td>0983</td>
<td>Professional fees - clinic</td>
</tr>
<tr>
<td>0984</td>
<td>Professional fees - medical social services</td>
</tr>
<tr>
<td>0985</td>
<td>Professional fees - EKG</td>
</tr>
<tr>
<td>0986</td>
<td>Professional fees - EEG</td>
</tr>
<tr>
<td>0987</td>
<td>Professional fees - hospital visit</td>
</tr>
<tr>
<td>0988</td>
<td>Professional fees - consultation</td>
</tr>
<tr>
<td>0989</td>
<td>Professional fees - private duty nurse</td>
</tr>
<tr>
<td>0990</td>
<td>Patient convenience items - general classification</td>
</tr>
<tr>
<td>0991</td>
<td>Patient convenience items - cafeteria/guest tray</td>
</tr>
<tr>
<td>0992</td>
<td>Patient convenience items - private linen service</td>
</tr>
<tr>
<td>0993</td>
<td>Patient convenience items - telephone/telegraph</td>
</tr>
<tr>
<td>0994</td>
<td>Patient convenience items - tv/radio</td>
</tr>
<tr>
<td>0995</td>
<td>Patient convenience items - nonpatient room rentals</td>
</tr>
<tr>
<td>0996</td>
<td>Patient convenience items - late discharge charge</td>
</tr>
<tr>
<td>0997</td>
<td>Patient convenience items - admission kits</td>
</tr>
<tr>
<td>0998</td>
<td>Patient convenience items - beauty shop/barber</td>
</tr>
<tr>
<td>0999</td>
<td>Patient convenience items - other</td>
</tr>
<tr>
<td>1000</td>
<td>Behavioral health Accommodations – general</td>
</tr>
</tbody>
</table>
1001 = Behavioral health Accommodations – residential treatment psychiatric
1002 = Behavioral health Accommodations – residential treatment chemical dependency
2101 = Alternative Therapy Services – Acupuncture
2103 = Alternative Therapy Services – Massage
3101 = Adult Day Care – Medical and Social (hourly)
3103 = Adult Day Care – Medical and Social (daily)
3104 = Adult Day Care – Social (daily)
3109 = Adult Day Care – other

COMMENT: -
<table>
<thead>
<tr>
<th><strong>REV_CNTR_FROM_DT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong> Revenue Center From Date</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> This is the beginning date of service for the line item.</td>
</tr>
<tr>
<td><strong>TYPE:</strong> DATE</td>
</tr>
<tr>
<td><strong>LENGTH:</strong> 8</td>
</tr>
<tr>
<td><strong>SOURCE:</strong> Medicare Advantage Organizations (MAOs)</td>
</tr>
</tbody>
</table>
| **FILE(S):** IP Revenue  
SNF Revenue  
HH Revenue  
OP Revenue |
| **VALUES:** - |
| **COMMENT:** - |
**REV_CNTR_IDE_NDC_UPC_NUM**

**LABEL:** Revenue Center IDE, NDC, or UPC Number

**DESCRIPTION:** This field may contain one of three types of identifiers: the National Drug Code (NDC), the Universal Product Code (UPC), or the number assigned by the Food and Drug Administration (FDA) to an investigational device (IDE) after the manufacturer has approval to conduct a clinical trial.

The IDEs will have a revenue center code '0624'.

**TYPE:** CHAR

**LENGTH:** 24

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Revenue  
SNF Revenue  
HH Revenue  
OP Revenue

**VALUES:** -

**COMMENT:** This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim).
REV_CNTR_NDC_QTY

LABEL: Revenue Center National Drug Code (NDC) Quantity

DESCRIPTION: The quantity dispensed for the drug reflected on the revenue center line item.

TYPE: NUM

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue
          SNF Revenue
          HH Revenue
          OP Revenue

VALUES: -

COMMENT: The unit of measurement for the drug that was administered (e.g., grams, liters) is indicated in the variable called REV_CNTR_NDC_QTY_QLFR_CD.
**REV_CNTR_NDC_QTY_QLFR_CD**

**LABEL:** Revenue Center NDC Quantity Qualifier Code

**DESCRIPTION:** The code used to indicate the unit of measurement for the drug that was administered.

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** IP Revenue
SNF Revenue
HH Revenue
OP Revenue

**VALUES:**
- F2 = International Unit
- GR = Gram
- ML = Milliliter
- UN = Unit
- VY = Link Sequence Number (to report components for compound drug)
- XZ = Prescription Number

**COMMENT:** The quantity of the drug dispensed is indicated in the variable called REV_CNTR_NDC_QTY.
REV_CNTR_RNDRNG_PHYSN_NPI

LABEL: Revenue Center Rendering Physician NPI

DESCRIPTION: This variable is the National Provider Identifier (NPI) for the physician who rendered the services on the revenue center record.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue
         SNF Revenue
         HH Revenue
         OP Revenue

VALUES: -

COMMENT: -

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REV_CNTR_THRU_DT

LABEL: Revenue Center Thru Date

DESCRIPTION: This is the ending date of service for the line item

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Revenue
         SNF Revenue
         HH Revenue
         OP Revenue

VALUES: -

COMMENT: -
**REV_CNTR_UNIT_CNT**

**LABEL:** Revenue Center Unit Count

**DESCRIPTION:** A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on an institutional claim or encounter record.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):**
- IP Revenue
- SNF Revenue
- HH Revenue
- OP Revenue

**VALUES:** 0 - XXXXXX

**COMMENT:** When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.
RFRG_PHYSN_NPI

LABEL:  Carrier/DME Referring Physician NPI Number

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

TYPE:  CHAR

LENGTH:  10

SOURCE:  Medicare Advantage Organizations (MAOs)

FILE(S):  Carrier Base
          DME Base

VALUES:  -

COMMENT:  -
**RLT_COND_CD_SEQ**

**LABEL:** Claim Related Condition Code Sequence

**DESCRIPTION:** The sequence number of the claim related condition code (variable called CLM_RLT_COND_CD).

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** CCW

**FILE(S):** IP Condition Code File  
SNF Condition Code File  
HH Condition Code File  
OP Condition Code File

**VALUES:** -

**COMMENT:** -
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
<td>Claim Related Occurrence Code Sequence</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>The sequence number of the claim related occurrence code (variable called CLM_RLT_OCRNC_CD).</td>
</tr>
<tr>
<td><strong>TYPE:</strong></td>
<td>CHAR</td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
<td>CCW</td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

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**RLT_SPAN_CD_SEQ**

**LABEL:** Claim Related Span Code Sequence

**DESCRIPTION:** The sequence number of the related span code (variable called CLM_SPAN_CD).

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** CCW

**FILE(S):**
- IP Span Code File
- SNF Span Code File
- HH Span Code File
- OP Span Code File

**VALUES:** -

**COMMENT:** -

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<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RLT_VAL_CD_SEQ</td>
<td>Claim Related Value Code Sequence</td>
</tr>
<tr>
<td>LABEL:</td>
<td>Claim Related Value Code Sequence</td>
</tr>
<tr>
<td>DESCRIPTION:</td>
<td>The sequence number of the related claim value code (variable called CLM_VAL_CD).</td>
</tr>
<tr>
<td>TYPE:</td>
<td>CHAR</td>
</tr>
<tr>
<td>LENGTH:</td>
<td>2</td>
</tr>
<tr>
<td>SOURCE:</td>
<td>CCW</td>
</tr>
<tr>
<td>FILE(S):</td>
<td>IP Value Code File</td>
</tr>
<tr>
<td></td>
<td>SNF Value Code File</td>
</tr>
<tr>
<td></td>
<td>HH Value Code File</td>
</tr>
<tr>
<td></td>
<td>OP Value Code File</td>
</tr>
<tr>
<td>VALUES:</td>
<td>-</td>
</tr>
<tr>
<td>COMMENT:</td>
<td>-</td>
</tr>
</tbody>
</table>

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RNDRNG_PHYSN_NPI

LABEL: Rendering Physician NPI

DESCRIPTION: This variable is the National Provider Identifier (NPI) for the physician who rendered the services on the record.

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP Base
        SNF Base
        HH Base
        OP Base
        Carrier Base
        DME Base

VALUES: -

COMMENT: -
RSN_VISIT_CD1
RSN_VISIT_CD2
RSN_VISIT_CD3

**LABEL:** Reason for Visit Diagnosis Code 1-3

**DESCRIPTION:** The diagnosis code used to identify the patient’s reason for the Home Health (HH) encounter record or Hospital Outpatient visit. There are up to three reason for visit diagnosis codes on the claim.

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** Medicare Advantage Organizations (MAOs)

**FILE(S):** HH Base
OP Base

**VALUES:** -

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

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

LABEL:  CCW Beneficiary Random Sample Group

DESCRIPTION:  This variable indicates if the beneficiary is part of a random 1, 5, 15, or 20 percent sample of Medicare beneficiaries that the CCW creates using standard CMS processes. All associated encounter records for the sampled beneficiaries are identified in the encounter files.

TYPE:  CHAR

LENGTH:  2

SOURCE:  CCW

FILE(S):  IP Base
          SNF Base
          HH Base
          OP Base
          Carrier Base
          DME Base

VALUES:  01 =  Beneficiary included in the 1 percent sample for the year
          04 =  Beneficiary included in the 4 percent sample for the year
          15 =  Beneficiary included in the 15 percent sample for the year
          Null/missing = Beneficiary not included in any sample group for the year

COMMENT:  To use the random 5 percent sample, users must combine the 1 and 4 percent samples (i.e., specify that SAMPLE_GROUP can equal “01” or “04”). To use the 20 percent sample, users must combine the 1, 4, and 15 percent samples (i.e., specify that SAMPLE_GROUP can equal “01”, “04”, or “15”).

Beneficiaries are assigned to sample groups each year based on the last two digits of their Medicare Claim Account Numbers (CANs).
SRVC_MONTH

LABEL: Service Month

DESCRIPTION: The CCW-derived service month indicates the month and year when the service was provided, based on the claim through date (CLM_THRU_DT).

TYPE: DATE

LENGTH: 6

SOURCE: CCW

FILE(S): IP Base
         SNF Base
         HH Base
         OP Base
         Carrier Base
         DME Base

VALUES: 201501 – 201512

COMMENT: This field can be used to obtain a subset of encounter records for analytic purposes.
**LABEL:** Provider Tax Number

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

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** CCW

**FILE(S):** IP Base, SNF Base, HH Base, OP Base, Carrier Base, DME Base

**VALUES:** -

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