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Chronic Conditions Warehouse Virtual Research Data Center

Encounter Records Codebook

MAY 2025| VERSION 1.7

Revision Log

Date	Changed by	Revisions	Version
May 2025	K. Schneider	• Removed values to comply with NUBC™ licensing for: ○ CLM_IP_ADMSN_TYPE_CD ○ CLM_RLT_COND_CD ○ CLM_RLT_OCRNC_CD ○ CLM_SPAN_CD ○ CLM_SRC_IP_ADMSN_CD ○ CLM_VAL_CD ○ PTNT_DSCHRG_STUS_CD ○ REV_CNTR • Variable was removed because beneficiary sex is available in the Master Beneficiary Summary File	1.7
November 2024	S. Pietzsch	Updated CLM_DRG_CD to length 4	1.6
June 2023	K. Schneider	Added values and corresponding descriptions for CLM_FREQ_CD, CLM_RLT_OCRNC_CD, CLM_SRC_IP_ADMSN_CD, CLM_VAL_CD, and REV_CNTR. Edited values for BENE_STATE_CD (removed territories), BENE_STATE (added GU and UP) and both CLM_PLACE_OF_SRVC_CD and LINE_PLACE_OF_SRVC_CD (edited value descriptions for 02,18,19)	1.5
November 2020	K. Schneider K. Russell	Updated LINE_PLACE_OF_SRVC_CD description and CLM_VAL_CD values; migrated codebook to new document template	1.4
May 2020	K. Schneider	Updated state codes, added REV_CNTR values	1.3
December 2019	K. Schneider	Added CLM_PLACE_OF_SRVC_CD and RNDRNG_PHYSN_NPI to carrier and DME base claim layouts for 2016 encounter data files.	1.2
April 2019	K. Schneider	Added a variable to correspond with the final 2015 encounter data files: LINE_NUM_ORIG; edited description for CLM_LINE_NUM	1.1
April 2018	C. Alleman R. VanGilder K. Schneider	Initial release of codebook for Medicare encounter records	1.0

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the Medicare encounter records file. The guide includes several ways for users to quickly find the information they need:

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

The CCW team has included hyperlinks throughout the codebook to make it easier for users to navigate between the table of contents and the detailed entries for the individual variables:

- Clicking on any variable name in the Table of Contents takes users 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 takes users 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.

Quick links: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Variable Details

This section of the codebook contains one entry for each variable in the encounter records file. Each entry contains variable details to facilitate understanding and use of the variables.

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).

SHORT NAME: ADMTG_DGNS_CD

LONG NAME: ADMTG_DGNS_CD

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 ninth 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.

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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.

SHORT NAME: AT_PHYSN_NPI

LONG NAME: AT_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

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

SOURCE: Medicare Advantage Organizations (MAOs)

VALUES: —

COMMENT: —

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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).

SHORT NAME: AT_PHYSN_TXNMY_C

LONG NAME: AT_PHYSN_TXNMY_C

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. Refer, for example: http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

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BENE_CNTY_CD

LABEL: Beneficiary County Code from Claim (SSA)

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

SHORT NAME: BENE_CNTY_CD

LONG NAME: BENE_CNTY_CD

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.

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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.

SHORT NAME: BENE_DSCHRG_DT

LONG NAME: BENE_DSCHRG_DT

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP base
SNF base
HH base

VALUES: —

COMMENT: —

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BENE_ID

LABEL: Encrypted CCW Beneficiary ID

DESCRIPTION: The unique CCW identifier for a beneficiary.

The CCW assigns a unique beneficiary identification number to everyone 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, and MDS assessment data).

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

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

SHORT NAME: BENE_ID

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

FILE(S): All encounter files

VALUES: —

COMMENT: —

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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.

SHORT NAME: BENE_MDCR_STUS_CD

LONG NAME: BENE_MDCR_STUS_CD

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.

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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.

SHORT NAME: BENE_MLG_CNTCT_ZIP_CD

LONG NAME: BENE_MLG_CNTCT_ZIP_CD

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: —

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BENE_RACE_CD

LABEL: Beneficiary Race Code

DESCRIPTION: Race code of the beneficiary

SHORT NAME: BENE_RACE_CD

LONG NAME: BENE_RACE_CD

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.

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BENE_STATE

LABEL: State of Beneficiary (postal abbreviation)

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

SHORT NAME: BENE_STATE

LONG NAME: BENE_STATE

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
AS = American Samoa
AZ = Arizona
CA = California
CO = Colorado
CT = Connecticut
DC = District of Columbia
DE = Delaware
FL = Florida
GA = Georgia
GU = Guam
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
NV = Nevada
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
UP = U.S. Possessions
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.

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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.

SHORT NAME: BENE_STATE_CD

LONG NAME: BENE_STATE_CD

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:

00 = unknown state
01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin

53 = Wyoming
63 = U.S. Possessions
64 = American Samoa
65 = Guam
Null/missing = unknown state

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

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CLM_1ST_DGNS_E_CD

LABEL: First Claim Diagnosis E Code

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

SHORT NAME: CLM_1ST_DGNS_E_CD

LONG NAME: CLM_1ST_DGNS_E_CD

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 ninth 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).

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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.

SHORT NAME: CLM_ADMSN_DT

LONG NAME: CLM_ADMSN_DT

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.

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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).

SHORT NAME: CLM_BPRVDR_ADR_ZIP_CD

LONG NAME: CLM_BPRVDR_ADR_ZIP_CD

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: —

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CLM_BPRVDR_CITY_NAME

LABEL: Billing Provider Address — City

DESCRIPTION: This variable is the billing provider city name, as submitted on the encounter.

SHORT NAME: CLM_BPRVDR_CITY_NAME

LONG NAME: CLM_BPRVDR_CITY_NAME

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: —

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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.

SHORT NAME: CLM_BPRVDR_USPS_STATE_CD

LONG NAME: CLM_BPRVDR_USPS_STATE_CD

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
NV = Nevada
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: —

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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.

SHORT NAME: CLM_CHRT_RVW_SW

LONG NAME: CLM_CHRT_RVW_SW

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*.

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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.

SHORT NAME: CLM_CNTL_NUM

LONG NAME: CLM_CNTL_NUM

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).

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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.

SHORT NAME: CLM_DAY_CNT

LONG NAME: CLM_DAY_CNT

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

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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.

SHORT NAME: CLM_DRG_CD

LONG NAME: CLM_DRG_CD

TYPE: CHAR

LENGTH: 4

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.

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CLM_E_POA_IND_SW1
CLM_E_POA_IND_SW2
CLM_E_POA_IND_SW3
CLM_E_POA_IND_SW4
CLM_E_POA_IND_SW5
CLM_E_POA_IND_SW6
CLM_E_POA_IND_SW7
CLM_E_POA_IND_SW8
CLM_E_POA_IND_SW9
CLM_E_POA_IND_SW10

LABEL: Claim Diagnosis E Code I – 10 Diagnosis Present on Admission (POA) Indicator Code

DESCRIPTION: 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.

SHORT NAME:

CLM_E_POA_IND_SW1
CLM_E_POA_IND_SW2
CLM_E_POA_IND_SW3
CLM_E_POA_IND_SW4
CLM_E_POA_IND_SW5
CLM_E_POA_IND_SW6
CLM_E_POA_IND_SW7
CLM_E_POA_IND_SW8
CLM_E_POA_IND_SW9
CLM_E_POA_IND_SW10

LONG NAME:

CLM_E_POA_IND_SW1
CLM_E_POA_IND_SW2
CLM_E_POA_IND_SW3
CLM_E_POA_IND_SW4
CLM_E_POA_IND_SW5
CLM_E_POA_IND_SW6
CLM_E_POA_IND_SW7
CLM_E_POA_IND_SW8
CLM_E_POA_IND_SW9
CLM_E_POA_IND_SW10

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Inpatient 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: —

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CLM_FAC_TYPE_CD

LABEL: Claim Facility Type Code

DESCRIPTION: The type of facility.

SHORT NAME: CLM_FAC_TYPE_CD

LONG NAME: CLM_FAC_TYPE_CD

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).

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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.

SHORT NAME: CLM_FINL_ACTN_IND

LONG NAME: CLM_FINL_ACTN_IND

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.

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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.

SHORT NAME: CLM_FREQ_CD

LONG NAME: CLM_FREQ_CD

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
6 = Reserved for national assignment
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
Q = Claim Submitted for Reconsideration Outside of Timely Limits

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 three-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).

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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”).

SHORT NAME: CLM_FROM_DT

LONG NAME: CLM_FROM_DT

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_ADMSN_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.

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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.

SHORT NAME: CLM_IP_ADMSN_TYPE_CD

LONG NAME: CLM_IP_ADMSN_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP base
SNF base

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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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).

SHORT NAME: CLM_LINE_NUM

LONG NAME: CLM_LINE_NUM

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.

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CLM_LTST_CLM_IND

LABEL: Latest Claim Indicator

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

SHORT NAME: CLM_LTST_CLM_IND

LONG NAME: CLM_LTST_CLM_IND

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: —

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CLM_MDCL_REC

LABEL: Claim Medical Record Number

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

SHORT NAME: CLM_MDCL_REC

LONG NAME: CLM_MDCL_REC

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.

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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).

SHORT NAME: CLM_OBSLT_DT

LONG NAME: CLM_OBSLT_DT

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).

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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.

SHORT NAME: CLM_ORIG_CNTL_NUM

LONG NAME: CLM_ORIG_CNTL_NUM

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.

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CLM_PLACE_OF_SRVC_CD

LABEL: Claim Place of Service Code

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

SHORT NAME: CLM_PLACE_OF_SRVC_CD

LONG NAME: CLM_PLACE_OF_SRVC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier base
DME base

VALUES:

00 = Unknown

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

02 = Telehealth —the location where health services and health related services are provided or received, through a telecommunication system.

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.

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, campground, 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 — a location, not described by any other POS code, owned, or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual.

19 = Off campus — outpatient hospital. A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

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 newborn 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 = Non-residential Opioid treatment facility

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
N5 = 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. https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

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CLM_POA_IND_SW1

CLM_POA_IND_SW2

CLM_POA_IND_SW3

CLM_POA_IND_SW4

CLM_POA_IND_SW5

CLM_POA_IND_SW6

CLM_POA_IND_SW7

CLM_POA_IND_SW8

CLM_POA_IND_SW9

CLM_POA_IND_SW10

CLM_POA_IND_SW11

CLM_POA_IND_SW12

CLM_POA_IND_SW13

CLM_POA_IND_SW14

CLM_POA_IND_SW15

CLM_POA_IND_SW16

CLM_POA_IND_SW17

CLM_POA_IND_SW18

CLM_POA_IND_SW19

CLM_POA_IND_SW20

CLM_POA_IND_SW21

CLM_POA_IND_SW22

CLM_POA_IND_SW23

CLM_POA_IND_SW24

CLM_POA_IND_SW25

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.

SHORT NAME:

CLM_POA_IND_SW1
CLM_POA_IND_SW2
CLM_POA_IND_SW3
CLM_POA_IND_SW4
CLM_POA_IND_SW5
CLM_POA_IND_SW6
CLM_POA_IND_SW7
CLM_POA_IND_SW8
CLM_POA_IND_SW9
CLM_POA_IND_SW10
CLM_POA_IND_SW11
CLM_POA_IND_SW12
CLM_POA_IND_SW13
CLM_POA_IND_SW14
CLM_POA_IND_SW15
CLM_POA_IND_SW16
CLM_POA_IND_SW17
CLM_POA_IND_SW18
CLM_POA_IND_SW19
CLM_POA_IND_SW20

CLM_POA_IND_SW21
CLM_POA_IND_SW22
CLM_POA_IND_SW23
CLM_POA_IND_SW24
CLM_POA_IND_SW25

LONG NAME:

CLM_POA_IND_SW1
CLM_POA_IND_SW2
CLM_POA_IND_SW3
CLM_POA_IND_SW4
CLM_POA_IND_SW5
CLM_POA_IND_SW6
CLM_POA_IND_SW7
CLM_POA_IND_SW8
CLM_POA_IND_SW9
CLM_POA_IND_SW10
CLM_POA_IND_SW11
CLM_POA_IND_SW12
CLM_POA_IND_SW13
CLM_POA_IND_SW14
CLM_POA_IND_SW15
CLM_POA_IND_SW16
CLM_POA_IND_SW17
CLM_POA_IND_SW18
CLM_POA_IND_SW19
CLM_POA_IND_SW20
CLM_POA_IND_SW21
CLM_POA_IND_SW22
CLM_POA_IND_SW23
CLM_POA_IND_SW24
CLM_POA_IND_SW25

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.

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CLM_RCPT_DT

LABEL: Claim Receipt Date

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

SHORT NAME: CLM_RCPT_DT

LONG NAME: CLM_RCPT_DT

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 is equal to or less than the EDPS_CREATE_DT.

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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.

SHORT NAME: CLM_RLT_COND_CD

LONG NAME: CLM_RLT_COND_CD

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: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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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).

SHORT NAME: CLM_RLT_OCRNC_CD

LONG NAME: CLM_RLT_OCRNC_CD

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: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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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.

SHORT NAME: CLM_RLT_OCRNC_DT

LONG NAME: CLM_RLT_OCRNC_DT

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: —

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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).

SHORT NAME: CLM_SPAN_CD

LONG NAME: CLM_SPAN_CD

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: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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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).

SHORT NAME: CLM_SPAN_FROM_DT

LONG NAME: CLM_SPAN_FROM_DT

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: —

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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).

SHORT NAME: CLM_SPAN_THRU_DT

LONG NAME: CLM_SPAN_THRU_DT

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: —

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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.

SHORT NAME: CLM_SRC_IP_ADMSN_CD

LONG NAME: CLM_SRC_IP_ADMSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP base

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

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CLM_SRVC_CLSFCTN_TYPE_CD

LABEL: Claim Service Classification Type Code

DESCRIPTION: The type of service provided to the beneficiary.

SHORT NAME: CLM_SRVC_CLSFCTN_TYPE_CD

LONG NAME: CLM_SRVC_CLSFCTN_TYPE_CD

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).

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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.

SHORT NAME: CLM_SUBSCR_ADR_ZIP_CD

LONG NAME: CLM_SUBSCR_ADR_ZIP_CD

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: —

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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.

SHORT NAME: CLM_SUBSCR_CITY_NAME

LONG NAME: CLM_SUBSCR_CITY_NAME

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: —

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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.

SHORT NAME: CLM_SUBSCR_USPS_STATE_CD

LONG NAME: CLM_SUBSCR_USPS_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

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

VALUES:

AA = Armed Forces, Americas
AE = Armed Forces, Europe/Middle East/Africa/Canada
AK = Alaska
AL = Alabama
AP = Armed Forces, Pacific
AR = Arkansas
AS = American Samoa
AZ = Arizona
CA = California
CO = Colorado
CT = Connecticut
DC = District of Columbia
DE = Delaware
FL = Florida
FM = Federated States of Micronesia
GA = Georgia
GU = Guam
HI = Hawaii
IA = Iowa
ID = Idaho
IL = Illinois
IN = Indiana
KS = Kansas
KY = Kentucky
LA = Louisiana
MA = Massachusetts
MD = Maryland
ME = Maine
MH = Marshall Islands
MI = Michigan
MN = Minnesota
MO = Missouri
MP = Northern Mariana Islands
MS = Mississippi
MT = Montana
NC = North Carolina
ND = North Dakota
NE = Nebraska
NH = New Hampshire
NJ = New Jersey
NM = New Mexico
NV = Nevada
NY = New York
OH = Ohio
OK = Oklahoma
OR = Oregon
PA = Pennsylvania
PR = Puerto Rico
PW = Palau
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_THRU_DT

LABEL: Claim Through Date

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

SHORT NAME: CLM_THRU_DT

LONG NAME: CLM_THRU_DT

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.

^ Back to TOC ^

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.

SHORT NAME: CLM_TYPE_CD

LONG NAME: CLM_TYPE_CD

TYPE: CHAR

LENGTH: 4

SOURCE: Medicare Advantage Organizations (MAOs)

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

VALUES:

4011 = Hospital inpatient
4041 = Religious Nonmedical Health Care Institutions — Hospital inpatient
4018 = Hospital Swing Beds
4021 = SNF Skilled Nursing inpatient
4028 = SNF Skilled Nursing Swing Beds
4032 = Home health + inpatient (covered by Medicare Part B – not Part A)
4033 = Home health + outpatient
4012 = Hospital inpatient (covered by Medicare Part B – not Part A)
4013 = Hospital outpatient
4014 = Hospital laboratory services provided to non-patients
4022 = SNF skilled nursing inpatient (covered by Medicare Part B – not Part A)
4023 = SNF skilled nursing outpatient
4034 = Home health + laboratory services provided to non-patients
4071 = Clinic (RHC) Rural Health
4072 = Clinic (ESRD) Renal Dialysis Hospital based or Independent
4073 = Clinic Freestanding
4074 = Clinic (ORF) Outpatient Rehab Facility
4075 = Clinic (CORF) Comprehensive Outpatient Rehab Facility
4076 = Clinic (CMHC) Community Mental Health Centers
4077 = Clinic (FQHC) Federal Qualified Health Center
4079 = Clinic — Other
4083 = Special Facility (ASC) Ambulatory Surgery Center
4085 = Special Facility (CAH) Critical Access Hospital
4089 = Special Facility — Other
4700 = Professional
4800 = DME

COMMENT: —

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CLM_VAL_CD

LABEL: Claim Value Code

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

SHORT NAME: CLM_VAL_CD

LONG NAME: CLM_VAL_CD

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: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

^ Back to TOC ^

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.

SHORT NAME: CNTRCT_NUM

LONG NAME: CNTRCT_NUM

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) to identify the specific plan in which a beneficiary was enrolled.

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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.

SHORT NAME: CNTRCT_PBP_NUM

LONG NAME: CNTRCT_PBP_NUM

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) 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

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DOB_DT

LABEL: Date of Birth from Encounter

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

SHORT NAME: DOB_DT

LONG NAME: DOB_DT

TYPE: DATE

LENGTH: 8

SOURCE: CMS Common Medicare Environment (CME)

FILE(S): IP base
SNF base
HH base
Carrier base
DME base

VALUES: —

COMMENT: —

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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).

SHORT NAME:

LONG NAME:

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.

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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.

SHORT NAME: EDPS_CREATE_DT

LONG NAME: EDPS_CREATE_DT

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 typically equals to or less than the EDPS_CREATN_DT.

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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.

SHORT NAME: ENC_JOIN_KEY

LONG NAME: ENC_JOIN_KEY

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.

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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.

SHORT NAME:

LONG NAME:

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: —

^ Back to TOC ^

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 (Refer to COMMENT section below).

SHORT NAME: HCPCS_CD

LONG NAME: HCPCS_CD

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

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

Note 1:

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

Level II

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

Level III

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

Note 2:

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

This field contains a HIPPS code if the revenue center code (REV_CNTR) equals 0022 for SNF care, 0023 for home health, or 0024 for IRF care.

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ICD_DGNS_CD1

ICD_DGNS_CD2

ICD_DGNS_CD3

ICD_DGNS_CD4

ICD_DGNS_CD5

ICD_DGNS_CD6

ICD_DGNS_CD7

ICD_DGNS_CD8

ICD_DGNS_CD9

ICD_DGNS_CD10

ICD_DGNS_CD11

ICD_DGNS_CD12

ICD_DGNS_CD13

ICD_DGNS_CD14

ICD_DGNS_CD15

ICD_DGNS_CD16

ICD_DGNS_CD17

ICD_DGNS_CD18

ICD_DGNS_CD19

ICD_DGNS_CD20

ICD_DGNS_CD21

ICD_DGNS_CD22

ICD_DGNS_CD23

ICD_DGNS_CD24

ICD_DGNS_CD25

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).

SHORT NAME:

ICD_DGNS_CD1
ICD_DGNS_CD2
ICD_DGNS_CD3
ICD_DGNS_CD4
ICD_DGNS_CD5
ICD_DGNS_CD6
ICD_DGNS_CD7
ICD_DGNS_CD8
ICD_DGNS_CD9
ICD_DGNS_CD10
ICD_DGNS_CD11
ICD_DGNS_CD12
ICD_DGNS_CD13
ICD_DGNS_CD14
ICD_DGNS_CD15
ICD_DGNS_CD16
ICD_DGNS_CD17
ICD_DGNS_CD18
ICD_DGNS_CD19
ICD_DGNS_CD20
ICD_DGNS_CD21
ICD_DGNS_CD22
ICD_DGNS_CD23
ICD_DGNS_CD24
ICD_DGNS_CD25

LONG NAME:

ICD_DGNS_CD1 ICD_DGNS_CD2

ICD_DGNS_CD3
ICD_DGNS_CD4
ICD_DGNS_CD5
ICD_DGNS_CD6
ICD_DGNS_CD7
ICD_DGNS_CD8
ICD_DGNS_CD9
ICD_DGNS_CD10
ICD_DGNS_CD11
ICD_DGNS_CD12
ICD_DGNS_CD13
ICD_DGNS_CD14
ICD_DGNS_CD15
ICD_DGNS_CD16
ICD_DGNS_CD17
ICD_DGNS_CD18
ICD_DGNS_CD19
ICD_DGNS_CD20
ICD_DGNS_CD21
ICD_DGNS_CD22
ICD_DGNS_CD23
ICD_DGNS_CD24
ICD_DGNS_CD25

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 ninth 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.

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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).

SHORT NAME:

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

LONG NAME:

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

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 ninth 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.

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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 orICD-10.

SHORT NAME:

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

LONG NAME:

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

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 ninth 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.

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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.

SHORT NAME:

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

LONG NAME:

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

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.

^ Back to TOC ^

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.

SHORT NAME: LINE_1ST_EXPNS_DT

LONG NAME: LINE_1ST_EXPNS_DT

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier line
DME line

VALUES: —

COMMENT: —

^ Back to TOC ^

LINE_LAST_EXPNS_DT

LABEL: Line Last Expense Date

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

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

SHORT NAME: LINE_LAST_EXPNS_DT

LONG NAME: LINE_LAST_EXPNS_DT

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier line
DME line

VALUES: —

COMMENT: —

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LINE_LTST_CLM_IND

LABEL: Line Latest Claim Indicator

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

SHORT NAME: LINE_LTST_CLM_IND

LONG NAME: LINE_LTST_CLM_IND

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: —

^ Back to TOC ^

LINE_NDC_CD

LABEL: Line National Drug Code (NDC)

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

SHORT NAME: LINE_NDC_CD

LONG NAME: LINE_NDC_CD

TYPE: CHAR

LENGTH: 11

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line
DME Line

VALUES: —

COMMENT: —

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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).

SHORT NAME: LINE_NUM_ORIG

LONG NAME: LINE_NUM_ORIG

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.

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LINE_PLACE_OF_SRVC_CD

LABEL: Line Place of Service Code

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

SHORT NAME: LINE_PLACE_OF_SRVC_CD

LONG NAME: LINE_PLACE_OF_SRVC_CD

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 = Telehealth. The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
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.
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, campground, 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. A location, not described by any other POS code, owned, or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual.

19 = Off campus — outpatient hospital. A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)

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 newborn 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 = Non-residential Opioid treatment facility
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
N5 = Unknown
N6 = Unknown
ND = Unknown
P0 = Unknown
SE = Unknown
XY = Unknown

ZZ = Unknown
Null/missing = unknown

COMMENT: Starting in 2016 there is also a base claim-level place of service code (variable called CLM_PLACE_OF_SRVC_CD).

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

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

^ Back to TOC ^

LINE_RX_NUM

LABEL: Carrier Line RX Number

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

SHORT NAME: LINE_RX_NUM

LONG NAME: LINE_RX_NUM

TYPE: CHAR

LENGTH: 30

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier Line

VALUES: —

COMMENT: —

^ Back to TOC ^

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.

SHORT NAME: LINE_SRVC_CNT

LONG NAME: LINE_SRVC_CNT

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: —

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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).

SHORT NAME: OP_PHYSN_NPI

LONG NAME: OP_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP base

SNF base

HH base

OP base

VALUES: —

COMMENT: —

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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.

SHORT NAME:

LONG NAME:

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: —

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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).

SHORT NAME: ORG_TXNMY_CD

LONG NAME: ORG_TXNMY_CD

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: Taxonomy codes are assigned by the National Uniform Claims Committee (NUCC). For a current list of NUCC Provider Taxonomy Codes and Descriptions, refer to the Code Sets link at http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

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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.

SHORT NAME: OT_PHYSN_NPI

LONG NAME: OT_PHYSN_NPI

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).

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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.

SHORT NAME:

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

LONG NAME:

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

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP base
SNF base
OP base

VALUES: —

COMMENT: —

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PRNCPAL_DGNS_CD

LABEL: Claim Principal Diagnosis Code

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

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

SHORT NAME: PRNCPAL_DGNS_CD

LONG NAME: PRNCPAL_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: Medicare Advantage Organizations (MAOs)

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

VALUES: —

COMMENT: —

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PRNCPAL_DGNS_VRSN_CD

LABEL: Claim Principal Diagnosis Version Code

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

SHORT NAME: PRNCPAL_DGNS_VRSN_CD

LONG NAME: PRNCPAL_DGNS_VRSN_CD

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 ninth version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

^ Back to TOC ^

PRVDR_NPI

LABEL: Line Rendering Physician NPI

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

SHORT NAME:

LONG NAME:

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier line
DME line

VALUES: —

COMMENT: —

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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).

SHORT NAME: PRVDR_SPCLTY

LONG NAME: PRVDR_SPCLTY

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: —

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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.

SHORT NAME:

LONG NAME:

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): IP base
SNF base

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™)
https://www.nubc.org/

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).

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REV_CNTR

LABEL: Revenue Center Code

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

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

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

SHORT NAME: REV_CNTR

LONG NAME: REV_CNTR

TYPE: CHAR

LENGTH: 4

SOURCE: Medicare Advantage Organizations (MAOs)

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

VALUES: This code set is an external code set maintained by the National Uniform Billing Committee (NUBC™) https://www.nubc.org/

COMMENT: —

^ Back to TOC ^

REV_CNTR_FROM_DT

LABEL: Revenue Center From Date

DESCRIPTION: This is the beginning date of service for the line item.

SHORT NAME: REV_CNTR_FROM_DT

LONG NAME: REV_CNTR_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

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

VALUES: —

COMMENT: —

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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 has a revenue center code "0624."

SHORT NAME: REV_CNTR_IDE_NDC_UPC_NUM

LONG NAME: REV_CNTR_IDE_NDC_UPC_NUM

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).

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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.

SHORT NAME: REV_CNTR_NDC_QTY

LONG NAME: REV_CNTR_NDC_QTY

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.

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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.

SHORT NAME: REV_CNTR_NDC_QTY_QLFR_CD

LONG NAME: REV_CNTR_NDC_QTY_QLFR_CD

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.

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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.

SHORT NAME: REV_CNTR_RNDRNG_PHYSN_NPI

LONG NAME: REV_CNTR_RNDRNG_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

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

VALUES: —

COMMENT: —

^ Back to TOC ^

REV_CNTR_THRU_DT

LABEL: Revenue Center Thru Date

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

SHORT NAME: REV_CNTR_THRU_DT

LONG NAME: REV_CNTR_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: Medicare Advantage Organizations (MAOs)

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

VALUES: —

COMMENT: —

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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.

SHORT NAME: REV_CNTR_UNIT_CNT

LONG NAME: REV_CNTR_UNIT_CNT

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 reflects the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

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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).

SHORT NAME: RFRG_PHYSN_NPI

LONG NAME: RFRG_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: Medicare Advantage Organizations (MAOs)

FILE(S): Carrier base

DME base

VALUES: —

COMMENT: —

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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).

SHORT NAME: RLT_COND_CD_SEQ

LONG NAME: RLT_COND_CD_SEQ

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: —

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RLT_OCRNC_CD_SEQ

LABEL: Claim Related Occurrence Code Sequence

DESCRIPTION: The sequence number of the claim related occurrence code (variable called CLM_RLT_OCRNC_CD).

SHORT NAME: RLT_OCRNC_CD_SEQ

LONG NAME: RLT_OCRNC_CD_SEQ

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

FILE(S): IP Occurrence Code File

SNF Occurrence Code File

HH Occurrence Code File

OP Occurrence Code File

VALUES: —

COMMENT: —

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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).

SHORT NAME: RLT_SPAN_CD_SEQ

LONG NAME: RLT_SPAN_CD_SEQ

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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RLT_VAL_CD_SEQ

LABEL: Claim Related Value Code Sequence

DESCRIPTION: The sequence number of the related claim value code (variable called CLM_VAL_CD).

SHORT NAME: RLT_VAL_CD_SEQ

LONG NAME: RLT_VAL_CD_SEQ

TYPE: CHAR

LENGTH: 2

SOURCE: CCW

FILE(S): IP Value Code File

SNF Value Code File

HH Value Code File

OP Value Code File

VALUES: —

COMMENT: —

^ Back to TOC ^

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.

SHORT NAME: RNDRNG_PHYSN_NPI

LONG NAME: RNDRNG_PHYSN_NPI

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: —

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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.

SHORT NAME: RSN_VISIT_CD1

RSN_VISIT_CD2

RSN_VISIT_CD3

LONG NAME: RSN_VISIT_CD1

RSN_VISIT_CD2

RSN_VISIT_CD3

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 ninth version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

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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.

SHORT NAME: SAMPLE_GROUP

LONG NAME: SAMPLE_GROUP

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).

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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).

SHORT NAME: SRVC_MONTH

LONG NAME: SRVC_MONTH

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.

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TAX_NUM

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.

SHORT NAME: TAX_NUM

LONG NAME: TAX_NUM

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).

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