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### Revision Log

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<th>Date</th>
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<tr>
<td>August 2023</td>
<td>K. Schneider</td>
<td>Added comment re: small number of incorrect NCH_CLM_TYPE_CD values. Added new values and descriptions for CLM_PRCR_RTRN_CD, CLM_RLT_COND_CD, CLM_RLT_OCRNC_CD, CLM_SPAN_CD, CLM_VAL_CD, DMERC_OXGN_INITL_DT_CD, LINE_OTHR_APLD_IND_CD1-7, LINE_PLACE_OF_SRVC_CD, and PRVDR_NUM. Updated web link for MedPAC Payment Basic series, and web link for revenue center codes (REV_CNTR)</td>
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<td>January 2023</td>
<td>K. Schneider</td>
<td>Added new fields and corresponding descriptions for: CLM_ADJUST_GRP_CD, CLM_ADJUST_RSN_CD, CLM_OP_PPS_IND, CLM_PRCR_VRSN_CD, DMERC_OXGN_EQUIP_INITL_DT, DMERC_OXGN_INITL_DT_CD, DMERC_OXGN_EQUIP_PRVS_DT, ESRD_TRMT_CHS_IND_CD, LINE_ADJUST_GRP_CD, LINE_ADJUST_RSN_CD, LINE_RA_RMRK_CD, MS_DRG_GRP_RVRN_CD, OWNG_PRVDR_TIN_NUM, PRVDR_FULL_CCN_NUM, REV_CNTR_ADJUST_GRP_CD, REV_CNTR_ADJUST_RSN_CD, REV_CNTR_RA_RMRK_CD, REV_CNTR_CRA_TPNIES_AMT, REV_CNTR_THRPY_RDCTN_AMT. Added values and corresponding descriptions for CARR_NUM, CLM_FREQ_CD, CLM_SRC_IP_ADMSN_CD, FI_NUM, REV_CNTR</td>
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<td>April 2022</td>
<td>K. Schneider, A. Sisco, A. Meyer</td>
<td>Added new fields and corresponding descriptions for AT_PHYSN_SPCLTY_CD, OP_PHYSN_SPCLTY_CD, OT_PHYSN_SPCLTY_CD, RFR_PHYSN_SPCLTY_CD, RNRNG_PHYSN_SPCLTY_CD, CLM_NEXT_GNRTN_ACO_IND_CD1-CLM_NEXT_GNRTN_ACO_IND_CD5, CLM_RLT_COND_CD, CLM_SRVC_CLSFCTN_TYPE_CD, DEMO_ID_NUM, LINE_OTHR_APLD_IND_CD1- LINE_OTHR_APLD_IND_CD7, REV_CNTR. Adjusted historical values and formatting for CARR_NUM and FI_NUM. Corrected values for CLM_VAL_CD, BENE_STATE_CD, DMERC_LINE_PRCNG_STATE_CD, and PRVDR_STATE_CD. Updated description for NCH_BENE_DSCHRG_DT and PRVDR_NUM.</td>
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<td>February 2021</td>
<td>K. Schneider, K. Russell, C. Alleman</td>
<td>Migrated codebook to 2020 document template. Added four fields due to NCH Version L updates: 1. LTCH_DSCHRG_PYMT_ADJSTMT_AMT to IP Base Claim; 2. ORDRG_PHYSN_NPI to hospice, HH and OP revenue lines; 3. RC_VLNTRY_SRVC_IND_CD to hospice, HH and OP revenue lines; 4. LINE_VLNTRY_SRVC_IND_CD to Carrier and DME lines. Also changed CLM_DRG_CD from three to four characters, and LINE_OTHR_APLD_IND_CD1-LINE_OTHR_APLD_IND_CD7 from one to two characters</td>
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| April 2020 | S. Pietzsch      | Added two fields to Part A layouts:  
  CLM_MODEL_REIMBRSMNT_AMT  
  RC_MODEL_REIMBRSMNT_AMT                                           | 1.6     |
| September 2019 | K. Schneider  | Added values and corresponding descriptions for  
  CLM_VAL_CD  
  LINE_OTHR_APLD_IND_CD1–7,  
  and provider specialty code  
  (AT_PHYSN_SPCLTY_CD, OP_PHYSN_SPCLTY_CD,  
  OT_PHYSN_SPCLTY_CD, RNDRNG_PHYSN_SPCLTY_CD, and  
  RFR_PHYSN_SPCLTY_CD)                                                 | 1.5     |
| May 2019 | C. Alleman        | Added new fields: 1) CLM_RSDL_PYMT_IND_CD to all base claims, and LINE_RSDL_PYMT_IND_CD to Carrier and DME lines;  
  2) CLM_RP_IND_CD to IP base claim, REV_CNTR_RP_IND_CD to SNF, HH, hospice and OP revenue lines, and LINE_RP_IND_CD to  
  Carrier and DME lines; 3) PRVDR_VLDTN_TYPE_CD to all base claims except for DME, and LINE_PRVDR_VLDTN_TYPE_CD to  
  Carrier and DME line; 4) RR_BRD_EXCLSN_IND_SW to IP, SNF, HH, hospice and OP base claims, and  
  LINE_RR_BRD_EXCLSN_IND_SW to DME line; 5) CLM_IP_INITL_MS_DRG_CD to IP base file; and 6)  
  DMERC_LINE_FRGN_ADR_IND to DME line.  
  Also changed the name of the HHA base field FINL_STD_AMT to be PPS_STD_VAL_PYMT_AMT; edited description of  
  FINL_STD_AMT and PPS_STD_VAL_PYMT_AMT.                              | 1.4     |
| January 2019 | C. Alleman  K. Schneider | Added new valid value for CLM_RLT_OCRNC_CD and new values for LINE_OTHR_APLD_IND_CD                                                                                                                      | 1.3     |
| August 2018 | C. Alleman        | Updated comments for variables: AT_PHYSN_SPCLTY_CD,  
  CARR_LINE_ANSTHSA_UNIT_CNT, LINE_SRVC_CNT, TAX_NUM.  
  Updated variable lengths: CARR_LINE_ANSTHSA_UNIT_CNT,  
  LINE_SRVC_CNT.  
  Updated values for LINE_PLACE_OF_SRVC_CD (values 02,18,19). | 1.2     |
| April 2018  | C. Alleman        | Updated TOC to sort on Long Name instead of Short Name.                                                                                                                                             | 1.1     |
| February 2018 | C. Alleman  K. Schneider | Initial release of Codebook for Medicare Fee-For-Service Claims,  
  Version K with CR13 updates.                                                                                                              | 1.0     |
**Tips on Navigating the Codebook**

This document is a detailed codebook that describes each variable in the Medicare fee-for-service (FFS) claims research files. We have included several ways for users to quickly find the information they need:

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

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

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

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**

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- ADMTG_DGNS_VRSN_CD ................................................................................................................................. 3
- AT_PHYSN_NPI .................................................................................................................................................... 4
- AT_PHYSN_SPCLTY_CD ...................................................................................................................................... 5
- AT_PHYSN_UPIN ................................................................................................................................................ 8
- BENE_CNTY_CD .................................................................................................................................................. 9
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- BENE_ID ........................................................................................................................................................... 11
- BENE_LRD_USED_CNT .................................................................................................................................... 12
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- BENE_STATE_CD .............................................................................................................................................. 15
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- BETOS_CD ....................................................................................................................................................... 18
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- CARR_CLM_CASH_DDCTBL_APLD_AMT ................................................................................................................ 21
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- CARR_CLM_RFRNG_PIN_NUM ............................................................................................................................ 28
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Variable Details

This section of the codebook contains one entry for each variable in the Medicare fee-for-service claims (Version L) files. Each entry contains variable details to facilitate understanding and use of the variables.

**ACO_ID_NUM**

**LABEL:** Claim Accountable Care Organization (ACO) Identification Number

**DESCRIPTION:** The field identifies the Accountable Care Organization (ACO) Identification Number.

**SHORT NAME:** ACO_ID_NUM

**LONG NAME:** ACO_ID_NUM

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** CMS began populating this field in 2016.
ADMTG_DGNS_CD

LABEL: Claim Admitting Diagnosis Code

DESCRIPTION: A diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission. This diagnosis code after evaluating the patient; it may be different from 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: NCH

VALUES: —

COMMENT: —
ADMTG_DGNS_VRSN_CD

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

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

SHORT NAME: ADMTG_DGNS_VRSN_CD

LONG NAME: ADMTG_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

**LABEL:** Claim Attending Physician NPI Number

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

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

**SHORT NAME:** AT_NPI

**LONG NAME:** AT_PHYSN_NPI

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**AT_PHYSN_SPCLTY_CD**

**LABEL:** Claim Attending Physician Specialty Code

**DESCRIPTION:** This variable is the code used to identify the CMS specialty code corresponding to the attending physician.

**SHORT NAME:** AT_PHYSN_SPCLTY_CD

**LONG NAME:** AT_PHYSN_SPCLTY_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/1/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative medicine
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathologist in private practice
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistant (eff. 4/1/2003 — previously grouped with Certified Registered Nurse Anesthetists (CRNA))
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company for DMERC (and not included in 51–53)
55 = Individual certified orthotic personnel certified by an accrediting organization
56 = Individual certified prosthetic personnel certified by an accrediting organization
57 = Individual certified prosthetic-orthotic personnel certified by an accrediting organization
58 = Medical supply company with registered pharmacist
59 = Ambulance service (private)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier (billing independently)
64 = Audiologist (billing independently)
65 = Physical therapist in private practice
66 = Rheumatology
67 = Occupational therapist in private practice
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Single or Multispecialty clinic or group practice (PA Group)
71 = Registered Dietician/Nutrition Professional (eff. 1/1/2002)
72 = Pain Management (eff. 1/1/2002)
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF)
75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/1/2003)
76 = Peripheral vascular disease
77 = Vascular surgery
78 = Cardiac surgery
79 = Addiction medicine
80 = Licensed clinical social worker
81 = Critical care (intensivists)
82 = Hematology
83 = Hematology/oncology
84 = Preventive medicine
85 = Maxillofacial surgery
86 = Neuropsychiatry
87 = All other suppliers (e.g., drug stores)
88 = Unknown provider
89 = Certified clinical nurse specialist
90 = Medical oncology
91 = Surgical oncology
92 = Radiation oncology
93 = Emergency medicine
94 = Interventional radiology
96 = Optician
97 = Physician assistant
98 = Gynecological/oncology
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = Skilled nursing facility (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/2007)
B2 = Pedorthic Personnel (eff. 10/2/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery (MDS) (eff. October 1, 2020)

COMMENT: CMS added this field to accommodate the Affordable Care Act (ACA) — for incentive payments to providers with specific primary care specialty designations. It was not populated before 2012. This field is not populated on inpatient or Skilled Nursing claims.
**AT_PHYSN_UPIN**

**LABEL:** Claim Attending Physician UPIN Number

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

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

**SHORT NAME:** AT_UPIN

**LONG NAME:** AT_PHYSN_UPIN

**TYPE:** CHAR

**LENGTH:** 6

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**BENE_CNTY_CD**

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

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

**SHORT NAME:** CNTY_CD

**LONG NAME:** BENE_CNTY_CD

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** SSA/EDB

**VALUES:** —

**COMMENT:** The US Census website lists county codes. 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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<tr>
<th><strong>BENE_HOSPC_PRD_CNT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
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<tr>
<td><strong>SOURCE:</strong></td>
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<tr>
<td><strong>VALUES:</strong></td>
</tr>
</tbody>
</table>
| **COMMENT:** | A series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” describe Medicare payments in detail. (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/))

**BENE_ID**

**LABEL:** Encrypted CCW Beneficiary ID

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

The CCW assigns a unique beneficiary identification number to each individual who receives Medicare and/or Medicaid and uses that number to identify an individual’s records in all CCW data files (e.g., Medicare claims, MAX claims, T-MSIS claims, and MDS assessment data).

This number does not change during a beneficiary’s lifetime, and CCW uses each number only once.

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

**SHORT NAME:** BENE_ID

**LONG NAME:** BENE_ID

**TYPE:** CHAR

**LENGTH:** 15

**SOURCE:** CCW

**VALUES:** —

**COMMENT:** —
**BENE_LRD_USED_CNT**

**LABEL:** Beneficiary Medicare Lifetime Reserve Days (LRD) Used Count

**DESCRIPTION:** The number of lifetime reserve days that the beneficiary has elected to use during the period covered by the institutional claim.

Under Medicare, each beneficiary has a one-time reserve of sixty additional days of inpatient hospital coverage that the patient can use after 90 days of inpatient care have been provided in a single benefit period.

This count subtracts from the total number of lifetime reserve days that a beneficiary has available.

**SHORT NAME:** LRD_USE

**LONG NAME:** BENE_LRD_USED_CNT

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**BENE_MLG_CNTCT_ZIP_CD**

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

**DESCRIPTION:** The beneficiaries’ mailing address ZIP code.

**SHORT NAME:** ZIP_CD

**LONG NAME:** BENE_MLG_CNTCT_ZIP_CD

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** EDB

**VALUES:** —

**COMMENT:** —
**BENE_RACE_CD**

**LABEL:** Beneficiary Race Code

**DESCRIPTION:** Race code from claim

**SHORT NAME:** RACE_CD

**LONG NAME:** BENE_RACE_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** SSA

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

**COMMENT:** —
**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:** STATE_CD

**LONG NAME:** BENE_STATE_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** SSA/EDB

**VALUES:**

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<td>63</td>
<td>U.S. Possessions</td>
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<td>64</td>
<td>American Samoa</td>
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<td>65</td>
<td>Guam</td>
</tr>
<tr>
<td>97</td>
<td>Northern Marianas</td>
</tr>
</tbody>
</table>
98 = Guam

99 = Unknown or if county code = 000 then this is American Samoa

COMMENT: —
**BENE_TOT_COINSRNC_DAYS_CNT**

**LABEL:** Beneficiary Total Coinsurance Days Count

**DESCRIPTION:** The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.

During each benefit period (calendar year), the beneficiary is responsible for coinsurance for particular days of inpatient care (no coinsurance from day 1 through day 60, then for days 61 through 90 there is 25% coinsurance), SNF care (no coinsurance until day 21, then is 1/8 of inpatient hospital deductible amount through 100th day of SNF).

Different rules apply for lifetime reserve days, etc.

**SHORT NAME:** COIN_DAY

**LONG NAME:** BENE_TOT_COINSRNC_DAYS_CNT

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**BETOS_CD**

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

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

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

**SHORT NAME:** BETOS

**LONG NAME:** BETOS_CD

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:**

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<th>Description</th>
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<td>M1B</td>
<td>Office visits — established</td>
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<td>M2A</td>
<td>Hospital visit — initial</td>
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<td>M2B</td>
<td>Hospital visit — subsequent</td>
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<td>M2C</td>
<td>Hospital visit — critical care</td>
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<td>M3</td>
<td>Emergency room visit</td>
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<td>M4A</td>
<td>Home visit</td>
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<td>M4B</td>
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<td>Specialist — ophthalmology</td>
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</tr>
<tr>
<td>P2B</td>
<td>Major procedure, cardiovascular—Aneurysm repair</td>
</tr>
<tr>
<td>P2C</td>
<td>Major Procedure, cardiovascular — Thromboendarterectomy</td>
</tr>
<tr>
<td>P2D</td>
<td>Major procedure, cardiovascular — Coronary angioplasty (PTCA)</td>
</tr>
<tr>
<td>P2E</td>
<td>Major procedure, cardiovascular — Pacemaker insertion</td>
</tr>
<tr>
<td>P2F</td>
<td>Major procedure, cardiovascular — Other</td>
</tr>
<tr>
<td>P3A</td>
<td>Major procedure, orthopedic — Hip fracture repair</td>
</tr>
<tr>
<td>P3B</td>
<td>Major procedure, orthopedic — Hip replacement</td>
</tr>
<tr>
<td>P3C</td>
<td>Major procedure, orthopedic — Knee replacement</td>
</tr>
<tr>
<td>P3D</td>
<td>Major procedure, orthopedic — other</td>
</tr>
<tr>
<td>P4A</td>
<td>Eye procedure — corneal transplant</td>
</tr>
<tr>
<td>P4B</td>
<td>Eye procedure — cataract removal/lens insertion</td>
</tr>
<tr>
<td>P4C</td>
<td>Eye procedure — retinal detachment</td>
</tr>
<tr>
<td>P4D</td>
<td>Eye procedure — treatment of retinal lesions</td>
</tr>
<tr>
<td>P4E</td>
<td>Eye procedure — other</td>
</tr>
<tr>
<td>P5A</td>
<td>Ambulatory procedures — skin</td>
</tr>
<tr>
<td>P5B</td>
<td>Ambulatory procedures — musculoskeletal</td>
</tr>
<tr>
<td>P5C</td>
<td>Ambulatory procedures — inguinal hernia repair</td>
</tr>
<tr>
<td>P5D</td>
<td>Ambulatory procedures — lithotripsy</td>
</tr>
<tr>
<td>P5E</td>
<td>Ambulatory procedures — other</td>
</tr>
<tr>
<td>P6A</td>
<td>Minor procedures — skin</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>P6B</td>
<td>Minor procedures — musculoskeletal</td>
</tr>
<tr>
<td>P6C</td>
<td>Minor procedures — other (Medicare fee schedule)</td>
</tr>
<tr>
<td>P6D</td>
<td>Minor procedures — other (non-Medicare fee schedule)</td>
</tr>
<tr>
<td>P7A</td>
<td>Oncology — radiation therapy</td>
</tr>
<tr>
<td>P7B</td>
<td>Oncology — other</td>
</tr>
<tr>
<td>P8A</td>
<td>Endoscopy — arthroscopy</td>
</tr>
<tr>
<td>P8B</td>
<td>Endoscopy — upper gastrointestinal</td>
</tr>
<tr>
<td>P8C</td>
<td>Endoscopy — sigmoidoscopy</td>
</tr>
<tr>
<td>P8D</td>
<td>Endoscopy — colonoscopy</td>
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<tr>
<td>P8E</td>
<td>Endoscopy — cystoscopy</td>
</tr>
<tr>
<td>P8F</td>
<td>Endoscopy — bronchoscopy</td>
</tr>
<tr>
<td>P8G</td>
<td>Endoscopy — laparoscopic cholecystectomy</td>
</tr>
<tr>
<td>P8H</td>
<td>Endoscopy — laryngoscopy</td>
</tr>
<tr>
<td>P8I</td>
<td>Endoscopy — other</td>
</tr>
<tr>
<td>P9A</td>
<td>Dialysis services (Medicare fee schedule)</td>
</tr>
<tr>
<td>P9B</td>
<td>Dialysis services (non-Medicare fee schedule)</td>
</tr>
<tr>
<td>I1A</td>
<td>Standard imaging — chest</td>
</tr>
<tr>
<td>I1B</td>
<td>Standard imaging — musculoskeletal</td>
</tr>
<tr>
<td>I1C</td>
<td>Standard imaging — breast</td>
</tr>
<tr>
<td>I1D</td>
<td>Standard imaging — contrast gastrointestinal</td>
</tr>
<tr>
<td>I1E</td>
<td>Standard imaging — nuclear medicine</td>
</tr>
<tr>
<td>I1F</td>
<td>Standard imaging — other</td>
</tr>
<tr>
<td>I2A</td>
<td>Advanced imaging — CAT/CT/CTA: brain/head/neck</td>
</tr>
<tr>
<td>I2B</td>
<td>Advanced imaging — CAT/CT/CTA: other</td>
</tr>
<tr>
<td>I2C</td>
<td>Advanced imaging — MRI/MRA: brain/head/neck</td>
</tr>
<tr>
<td>I2D</td>
<td>Advanced imaging — MRI/MRA: other</td>
</tr>
<tr>
<td>I3A</td>
<td>Echography/ultrasonography — eye</td>
</tr>
<tr>
<td>I3B</td>
<td>Echography/ultrasonography — abdomen/pelvis</td>
</tr>
<tr>
<td>I3C</td>
<td>Echography/ultrasonography — heart</td>
</tr>
<tr>
<td>I3D</td>
<td>Echography/ultrasonography — carotid arteries</td>
</tr>
<tr>
<td>I3E</td>
<td>Echography/ultrasonography — prostate, transrectal</td>
</tr>
<tr>
<td>I3F</td>
<td>Echography/ultrasonography — other</td>
</tr>
<tr>
<td>I4A</td>
<td>Imaging/procedure — heart including cardiac catheterization</td>
</tr>
<tr>
<td>I4B</td>
<td>Imaging/procedure — other</td>
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<tr>
<td>T1A</td>
<td>Lab tests — routine venipuncture (non-Medicare fee schedule)</td>
</tr>
<tr>
<td>T1B</td>
<td>Lab tests — automated general profiles</td>
</tr>
<tr>
<td>T1C</td>
<td>Lab tests — urinalysis</td>
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<tr>
<td>T1D</td>
<td>Lab tests — blood counts</td>
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<tr>
<td>T1E</td>
<td>Lab tests — glucose</td>
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<tr>
<td>T1F</td>
<td>Lab tests — bacterial cultures</td>
</tr>
<tr>
<td>T1G</td>
<td>Lab tests — other (Medicare fee schedule)</td>
</tr>
<tr>
<td>T1H</td>
<td>Lab tests — other (non-Medicare fee schedule)</td>
</tr>
<tr>
<td>T2A</td>
<td>Other tests — electrocardiograms</td>
</tr>
<tr>
<td>T2B</td>
<td>Other tests — cardiovascular stress tests</td>
</tr>
<tr>
<td>T2C</td>
<td>Other tests — EKG monitoring</td>
</tr>
<tr>
<td>T2D</td>
<td>Other tests — other</td>
</tr>
<tr>
<td>D1A</td>
<td>Medical/surgical supplies</td>
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<tr>
<td>D1B</td>
<td>Hospital beds</td>
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<tr>
<td>D1C</td>
<td>Oxygen and supplies</td>
</tr>
<tr>
<td>D1D</td>
<td>Wheelchairs</td>
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<tr>
<td>D1E</td>
<td>Other DME</td>
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<tr>
<td>D1F</td>
<td>Prosthetic/Orthotic devices</td>
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<tr>
<td>D1G</td>
<td>Drugs Administered through DME</td>
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<tr>
<td>O1A</td>
<td>Ambulance</td>
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<tr>
<td>O1B</td>
<td>Chiropractic</td>
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<tr>
<td>O1C</td>
<td>Enteral and parenteral</td>
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<tr>
<td>O1D</td>
<td>Chemotherapy</td>
</tr>
<tr>
<td>O1E</td>
<td>Other drugs</td>
</tr>
<tr>
<td>O1F</td>
<td>Hearing and speech services</td>
</tr>
<tr>
<td>O1G</td>
<td>Immunizations/Vaccinations</td>
</tr>
<tr>
<td>Y1</td>
<td>Other — Medicare fee schedule</td>
</tr>
<tr>
<td>Y2</td>
<td>Other — non-Medicare fee schedule</td>
</tr>
<tr>
<td>Z1</td>
<td>Local codes</td>
</tr>
<tr>
<td>Z2</td>
<td>Undefined codes</td>
</tr>
</tbody>
</table>

**COMMENT:** CMS derives this field using a Healthcare Common Procedure Coding System (HCPCS) code to BETOS code crosswalk.
<table>
<thead>
<tr>
<th><strong>CARR_CLM_BLG_NPI_NUM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong> Carrier Claim Billing NPI Number</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> The CMS National Provider Identifier (NPI) number assigned to the billing provider</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong> CARR_CLM_BLG_NPI_NUM</td>
</tr>
<tr>
<td><strong>LONG NAME:</strong> CARR_CLM_BLG_NPI_NUM</td>
</tr>
<tr>
<td><strong>TYPE:</strong> CHAR</td>
</tr>
<tr>
<td><strong>LENGTH:</strong> 10</td>
</tr>
<tr>
<td><strong>SOURCE:</strong> NCH</td>
</tr>
<tr>
<td><strong>VALUES:</strong> —</td>
</tr>
<tr>
<td><strong>COMMENT:</strong> —</td>
</tr>
</tbody>
</table>
**CARR_CLM_CASH_DDCTBL_APLD_AMT**

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

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

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

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

**SHORT NAME:** DEDAPPLY

**LONG NAME:** CARR_CLM_CASH_DDCTBL_APLD_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** The Medicare.gov website describes beneficiaries’ costs in detail. There is a CMS publication called "Your Medicare Benefits," which explains the deductibles.

^ Back to TOC ^
CARR_CLM_ENTRY_CD

LABEL: Carrier Claim Entry Code

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

SHORT NAME: ENTRY_CD

LONG NAME: CARR_CLM_ENTRY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —
**CARR_CLM_HCPCS_YR_CD**

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

**DESCRIPTION:** The Healthcare Common Procedure Coding System (HCPCS) uses this terminal digit to code the claim.

**SHORT NAME:** HCPCS_YR

**LONG NAME:** CARR_CLM_HCPCS_YR_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

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

**COMMENT:** —
**CARR_CLM_PMT_DNL_CD**

**LABEL:** Carrier Claim Payment Denial Code

**DESCRIPTION:** The code on a non-institutional claim indicating who receives payment or if the claim was denied.

**SHORT NAME:** PMTDNLCD

**LONG NAME:** CARR_CLM_PMT_DNL_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

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

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Denied</td>
</tr>
<tr>
<td>1</td>
<td>Physician/supplier</td>
</tr>
<tr>
<td>2</td>
<td>Beneficiary</td>
</tr>
<tr>
<td>3</td>
<td>Both physician/supplier and beneficiary</td>
</tr>
<tr>
<td>4</td>
<td>Hospital (hospital-based physicians)</td>
</tr>
<tr>
<td>5</td>
<td>Both hospital and beneficiary</td>
</tr>
<tr>
<td>6</td>
<td>Group practice prepayment plan</td>
</tr>
<tr>
<td>7</td>
<td>Other entries (e.g., Employer, union)</td>
</tr>
<tr>
<td>8</td>
<td>Federally funded</td>
</tr>
<tr>
<td>9</td>
<td>PA service</td>
</tr>
<tr>
<td>A</td>
<td>Beneficiary under limitation of liability</td>
</tr>
<tr>
<td>B</td>
<td>Physician/supplier under limitation of liability</td>
</tr>
<tr>
<td>D</td>
<td>Denied due to demonstration involvement</td>
</tr>
<tr>
<td>E</td>
<td>MSP cost avoided IRS/SSA/HCFA Data Match (after 01/2001 is First Claim Development)</td>
</tr>
<tr>
<td>F</td>
<td>MSP cost avoided HMO Rate Cell (after 1/2001 is Trauma Code Development)</td>
</tr>
<tr>
<td>G</td>
<td>MSP cost avoided Litigation Settlement (after 1/2001 is Secondary Claims Investigation)</td>
</tr>
<tr>
<td>H</td>
<td>MSP cost avoided Employer Voluntary Reporting (after 1/2001 is Self-Reports)</td>
</tr>
<tr>
<td>J</td>
<td>MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/2000)</td>
</tr>
<tr>
<td>K</td>
<td>MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/2000)</td>
</tr>
<tr>
<td>P</td>
<td>Physician ownership denial</td>
</tr>
<tr>
<td>Q</td>
<td>MSP cost avoided — voluntary agreements including with employer</td>
</tr>
<tr>
<td>T</td>
<td>MSP cost avoided — Initial Enrollment Questionnaire</td>
</tr>
<tr>
<td>U</td>
<td>MSP cost avoided — HMO rate cell adjustment</td>
</tr>
<tr>
<td>V</td>
<td>MSP cost avoided — litigation settlement</td>
</tr>
<tr>
<td>X</td>
<td>MSP cost avoided — generic</td>
</tr>
<tr>
<td>Y</td>
<td>MSP cost avoided — IRS/SSA data match</td>
</tr>
<tr>
<td>00</td>
<td>MSP cost avoided — COB Contractor</td>
</tr>
<tr>
<td>12</td>
<td>MSP cost avoided — BC/BS Voluntary Data Sharing Agreements (VDSA)</td>
</tr>
<tr>
<td>13</td>
<td>MSP cost avoided — Office of Personnel Management (OPM) Data Match</td>
</tr>
<tr>
<td>14</td>
<td>MSP cost avoided — Workman’s Compensation (WC) Data Match</td>
</tr>
<tr>
<td>15</td>
<td>MSP cost avoided — Workman’s Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA)</td>
</tr>
<tr>
<td>16</td>
<td>MSP cost avoided — Liability Insurer VDSA</td>
</tr>
</tbody>
</table>
17 = MSP cost avoided — No-Fault Insurer VDSA
18 = MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement
19 = MSP cost avoided — Worker’s Compensation Medicare Set-Aside Arrangement (eff. 4/2006)
21 = MSP cost avoided — MIR Group Health Plan
22 = MSP cost avoided — MIR non-Group Health Plan
25 = MSP cost avoided — Recovery Audit Contractor — California
26 = MSP cost avoided — Recovery Audit Contractor — Florida
41 = MSP cost avoided — non-Group Health Plan non-Ongoing responsibility for medical (ORM)
43 = MSP cost avoided — Medicare Part C/Medicare Advantage

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

! = MSP cost avoided — COB Contractor (converted to '00' 2-byte code)
@ = MSP cost avoided — BC/BS Voluntary Agreements (converted to '12' 2-byte code)
# = MSP cost avoided — Office of Personnel Management (converted to '13' 2-byte code)
$ = MSP cost avoided — Workman’s Compensation (WC) Datamatch (converted to '14' 2-byte code)
* = MSP cost avoided — Workman’s Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006) (converted to '15' 2-byte code)
( = MSP cost avoided — Liability Insurer VDSA (eff. 4/2006) (converted to '16' 2-byte code)
) = MSP cost avoided — No-Fault Insurer VDSA (eff. 4/2006) (converted to '17' 2-byte code)
+ = MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006) (converted to '18' 2-byte code)
< = MSP cost avoided — MIR Group Health Plan (eff. 1/2009) (converted to '21' 2-byte code)
> = MSP cost avoided — MIR non-Group Health Plan (eff. 1/2009) (converted to '22' 2-byte code)
% = MSP cost avoided — Recovery Audit Contractor — California (eff. 10/2005) (converted to '25' 2-byte code)
& = MSP cost avoided — Recovery Audit Contractor — Florida (eff. 10/2005) (converted to '26' 2-byte code)

COMMENT: Effective with Version ‘J,’ the field was expanded on the NCH record to 2 bytes, with his expansion, the NCH will no longer use the character values to represent the official two-byte values sent in by NCH since 4/2002. During the Version J conversion, all character values were converted to the two-byte values.
On 4/1/2002, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value.
**CARR_CLM_PRVDR_ASGNMT_IND_SW**

**LABEL:** Carrier Claim Provider Assignment Indicator Switch

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

**SHORT NAME:** ASGMNTCD

**LONG NAME:** CARR_CLM_PRVDR_ASGNMT_IND_SW

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

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

**COMMENT:** —
CARR_CLM_RFRNG_PIN_NUM

LABEL: Carrier Claim Referring Provider ID Number (PIN)

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

SHORT NAME: RFR_PRFL

LONG NAME: CARR_CLM_RFRNG_PIN_NUM

TYPE: CHAR

LENGTH: 14

SOURCE: NCH

VALUES: —

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

LABEL: Carrier Claim Site of Service NPI Number

DESCRIPTION: This field identifies the Site of Service National Provider Identifier (NPI).

SHORT NAME: CARR_CLM_SOS_NPI_NUM

LONG NAME: CARR_CLM_SOS_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated prior to 2009.
CARR_LINE_ANSTHSA_UNIT_CNT

LABEL: Carrier Line Anesthesia Unit Count

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

SHORT NAME: CARR_LINE_ANSTHSA_UNIT_CNT

LONG NAME: CARR_LINE_ANSTHSA_UNIT_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field may have decimals (it is formatted as SAS length 11.3). Prior to Version ‘J,’ this field was S9(3), Length 7.3.
**CARR_LINE_CL_CHRG_AMT**

LABEL: Carrier Line Clinical Lab Charge Amount  
DESCRIPTION: Clinical lab charge amount on the Carrier line.  
SHORT NAME: CARR_LINE_CL_CHRG_AMT  
LONG NAME: CARR_LINE_CL_CHRG_AMT  
TYPE: NUM  
LENGTH: 12  
SOURCE: NCH  
VALUES: XXX.XX  
COMMENT: —
<table>
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<tr>
<th><strong>CARR_LINE_CLIA_LAB_NUM</strong></th>
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<tbody>
<tr>
<td><strong>LABEL:</strong></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong></td>
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<td><strong>TYPE:</strong></td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
</tr>
</tbody>
</table>
CARR_LINE_MDPP_NPI_NUM

LABEL: Carrier Line Medicare Diabetes Prevention Program (MDPP) NPI Number

DESCRIPTION: This field represents the National Provider Identifier (NPI) of the Medicare Diabetes Prevention Program (MDPP) Coach.

SHORT NAME: CARR_LINE_MDPP_NPI_NUM

LONG NAME: CARR_LINE_MDPP_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is new in April 2018.
**CARR_LINE_MTUS_CD**

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

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

SHORT NAME: MTUS_IND

LONG NAME: CARR_LINE_MTUS_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: —
**CARR_LINE_MTUS_CNT**

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

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

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

**SHORT NAME:** MTUS_CNT

**LONG NAME:** CARR_LINE_MTUS_CNT

**TYPE:** NUM

**LENGTH:** 11

**SOURCE:** NCH

**VALUES:** —

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

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**CARR_LINE_PRCNG_LCLTY_CD**

**LABEL:** Carrier Line Pricing Locality Code

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

**SHORT NAME:** LCLTY_CD

**LONG NAME:** CARR_LINE_PRCNG_LCLTY_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:** Medicare Localities

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

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

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

1 = ALABAMA
2 = ALASKA
3 = ARIZONA
4 = ARKANSAS
5 = ANAHEIM/SANTA ANA, CA
6 = LOS ANGELES, CA
7 = MARIN/NAPA/SOLANO, CA
8 = OAKLAND/BERKELEY, CA
9 = REST OF CALIFORNIA
10 = SAN FRANCISCO, CA
11 = SAN MATEO, CA
12 = SANTA CLARA, CA
13 = VENTURA, CA
14 = COLORADO
15 = CONNECTICUT
16 = DC + MD/VA SUBURBS
17 = DELAWARE
18 = FORT LAUDERDALE, FL
19 = MIAMI, FL
20 = REST OF FLORIDA
21 = ATLANTA, GA
22 = REST OF GEORGIA
23 = HAWAII
24 = IDAHO
25 = CHICAGO, IL
26 = EAST ST. LOUIS, IL
27 = REST OF ILLINOIS
28 = SUBURBAN CHICAGO, IL
29 = INDIANA
30 = IOWA
31 = KANSAS
32 = KENTUCKY
33 = NEW ORLEANS, LA
34 = REST OF LOUISIANA
35 = REST OF MAINE
36 = SOUTHERN MAINE
37 = BALTIMORE/SURR. CNTYS, MD
38 = REST OF MARYLAND
39 = METROPOLITAN BOSTON
40 = REST OF MASSACHUSETTS
41 = DETROIT, MI
42 = REST OF MICHIGAN
43 = MINNESOTA
44 = MISSISSIPPI
45 = METROPOLITAN KANSAS CITY, MO
46 = METROPOLITAN ST. LOUIS, MO
Locality codes = 0, A1, A2, A3, A4, A5, A6, A7, B1, B2, B4, B5, B6, B7, B8, C1, C2, C3, C5, C7, C8, D2, D5, D6, D8, E1, E3, E5, E7, F2, F6, F7, F8, G1, G2, G3, G5, G6, G7, G8, G9, H4, H5, H8, H9, J2, J3, J4, J6, J7, and K4.

COMMENT: Carrier pricing locality isn’t maintained by CWF and CMS. Each MAC sets up their locality values that would be sent to CWF.
CARR_LINE_PRVDR_TYPE_CD

LABEL: Carrier Line Provider Type Code

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

SHORT NAME: PRV_TYPE

LONG NAME: CARR_LINE_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: For Physician/Supplier Claims:

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

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

0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
3 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
4 = Suppliers (other than sole proprietorship) for whom the carrier's own ID number is shown.
5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.
**CARR_LINE_RDCD_PMT_PHYS_ASTN_C**

**LABEL:** Carrier Line Reduced Payment Physician Assistant Code

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

**SHORT NAME:** ASTNT_CD

**LONG NAME:** CARR_LINE_RDCD_PMT_PHYS_ASTN_C

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- BLANK = Adjustment situation (where CLM_DISP_CD equal 3)
- 0 = N/A
- 1 = 65% of payment. Either physician assistants assisting in surgery or nurse midwives
- 2 = 75% of payment. Either physician assistants performing services in a hospital (other than assisting surgery) or nurse practitioners/clinical nurse specialist performing services in rural areas or clinical social worker services
- 3 = 85% of payment. Either physician assistant services for other than assisting surgery or other hospital services or nurse practitioners’ services (not in rural areas)

**COMMENT:** —

[^ Back to TOC ^]
CARR_LINE_RX_NUM

LABEL: Carrier Line RX Number

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

SHORT NAME: CARRXNUM

LONG NAME: CARR_LINE_RX_NUM

TYPE: CHAR

LENGTH: 30

SOURCE: NCH

VALUES: —

COMMENT: The prescription order number consists of:

- Vendor ID number (positions 1–4)
- HCPCS code (positions 5–9)
- Vendor controlled prescription number (positions 10–30)

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

**LABEL:** Carrier or MAC Number

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

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

**SHORT NAME:** CARR_NUM

**LONG NAME:** CARR_NUM

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:**

- 00510 = Alabama — CAHABA (eff. 1983; term. 05/2009)
- 00511 = Georgia — CAHABA (eff. 1998; term. 06/2009) (replaced by MAC #10202)
- 00512 = Mississippi — CAHABA (eff. 2000)
- 00520 = Arkansas BC/BS (eff. 1983)
- 00521 = New Mexico — Arkansas BC/BS (eff. 1998; term. 02/2008) (replaced by MAC #04202)
- 00522 = Oklahoma — Arkansas BC/BS (eff. 1998; term. 02/2008) (replaced by MAC #04302)
- 00523 = Missouri East — Arkansas BC/BS (eff. 1999; term. 02/2008) (replaced by MAC #05392)
- 00524 = Rhode Island — Arkansas BC/BS (eff. 2004; term. 01/2009) (replaced by MAC #14402)
- 00528 = Louisiana — Arkansas BS (eff. 1984)
- 00542 = California BS (eff. 1983; term. 05/2009)
- 00590 = Florida — First Coast (eff. 1983; term. 01/2009) (replaced by MAC #09102)
- 00591 = Connecticut — First Coast (eff. 2000; term. 07/2008) (replaced by MAC #13102)
- 00630 = Indiana — Administer (eff. 1983) (term. 08/19/2012) (replaced by MAC #08102)
- 00635 = DMERC-B — Administer (eff. 1993; term. 06/2006) (replaced by MAC #17003)
- 00650 = Kansas BCBS (eff. 1983; term. 02/2008) (replaced by MAC #05202)
- 00651 = Missouri — Kansas BCBS (eff. 1983; term. 02/2008) (replaced by MAC #05202)
- 00655 = Nebraska — Kansas BC/BS (eff. 1988; term. 02/2008) (replaced by MAC #05402)
- 00660 = Kentucky — Administer (eff. 1983; term. 04/2011)
- 00663 = FQHC Pilot Demo (CAFM — Ayers-Ramsey) (term. 11/2011)
- 00710 = Michigan BS (eff. 1983; term. 09/2000)
- 00720 = Minnesota BS (eff. 1983; term. 09/2000)
- 00740 = Western Missouri — Kansas BS (eff. 1983; term. 06/1997) (replaced by MAC #05302)
- 00751 = Montana BC/BS (eff. 1983; term. 11/2006) (replaced by MAC #03202)
- 00801 = New York — Health now (eff. 1983; term. 08/2008) (replaced by MAC #13282)
- 00803 = New York — Empire BS (eff. 1983; term. 07/2008) (replaced by MAC #13202)
- 00804 = New York — Rochester BS (term. 02/1999) (replaced by MAC #12402)
- 00805 = New Jersey — Empire BS (eff. 3/99; term. 11/2008) (replaced by MAC #12402)
- 00811 = DMERC (A) — Health now (eff. 2000; term. 06/2006) (replaced by MAC #16003)
- 00820 = North Dakota — Noridian (eff. 1983; term. 11/2006) (replaced by MAC #03302)
00823 = Utah — Noridian (eff. 12/1/2005; term. 11/2006) (replaced by MAC #03502)
00824 = Colorado — Noridian (eff. 1995; term. 02/2008) (replaced by MAC #04102)
00825 = Wyoming — Noridian (eff. 1990; term. 11/2006) (replaced by MAC #03602)
00826 = Iowa — Noridian (eff. 1999; term. 01/2008) (replaced by MAC #05102)
00831 = Alaska — Noridian (eff. 1998)
00832 = Arizona — Noridian (eff. 1998; term. 11/2006) (replaced by MAC #03102)
00833 = Hawaii — Noridian (eff. 1998; term. 07/2008) (replaced by MAC #01202)
00834 = Nevada — Noridian (eff. 1998; term. 07/2008) (replaced by MAC #01302)
00835 = Oregon — Noridian (eff. 1998)
00836 = Washington — Noridian (eff. 1998)
00865 = Pennsylvania — Highmark (eff. 1983; term. 12/2008) (replaced by MAC #12502)
00870 = Rhode Island BS (eff. 1983; term. 02/1999)
00880 = South Carolina — Palmetto (eff. 1983; term. 06/2011)
00882 = RRB — South Carolina PGBA (eff. 2000)
00883 = Ohio — Palmetto (eff. 2002; term. 06/2011)
00884 = West Virginia — Palmetto (eff. 2002; term. 06/2011)
00885 = DMERC C — Palmetto (eff. 1993; term. 05/2006) (replaced by MAC #18003)
00889 = South Dakota — Noridian (eff. 4/1/2006; term. 11/2006) (replaced by MAC #03402)
00900 = Texas — Trailblazer (eff. 1983; term. 06/2008) (replaced by MAC #04402)
00901 = Maryland — Trailblazer (eff. 1995; term. 07/2008) (replaced by MAC #12302)
00902 = Delaware — Trailblazer (eff. 1998; term. 07/2008) (replaced by MAC #12102)
00903 = District of Columbia — Trailblazer (eff. 1998; term. 07/2008) (replaced by MAC #12202)
00904 = Virginia — Trailblazer (eff. 2000; term. 03/2011) (replaced by MAC #11302)
00910 = Utah BS (eff. 1983; term. 09/2006)
00951 = Wisconsin — Wisconsin Phy Svc (eff. 1983)
00952 = Illinois — Wisconsin Phy Svc (eff. 1999)
00953 = Michigan — Wisconsin Phy Svc (eff. 1999; term. 07/15/2012) (replaced by MAC #08202)
00954 = Minnesota — Wisconsin Phy Svc (eff. 2000)
00960 = WPS Part D GAP (CAFM) (Truffer) (eff. 01/2010)
00973 = Puerto Rico — Triple S, Inc. (eff. 1983; term. 02/2009) (replaced by MAC #09302)
00974 = Triple-S, Inc. — Virgin Islands (term. 02/2009)
01002 = J1 Roll-up
01102 = California (eff. 9/1/08) (replaces carrier #00832)
1112 = California, Northern — Noridian Healthcare Solutions
11182 = California, Southern — Noridian Healthcare Solutions
01192 = Palmetto GBA J1 (S CA) (eff. 09/2001/2008)
01202 = Hawaii (eff. 8/1/08) (replaces carrier #00833)
1212 = American Samoa. Guam, Hawaii, Northern Mariana Islands — Noridian Healthcare Solutions
01302 = Nevada (eff. 8/1/08) (replaces carrier #00834)
1312 = Nevada — Noridian Healthcare Solutions
01380 = Oregon — AETNA (eff. 1983; term. 09/2000)
01390 = Washington — AETNA (eff. 1994; term. 09/2000)
02002 = JF Roll-up (2/3)
02050 = California — TOLIC (eff. 1983; term. 09/1991)
02102 = Alaska — Noridian Admin Svcs (eff. 02/2001/2012)
02202 = Idaho — Noridian Admin Svcs (eff. 02/2001/2012)
02302 = Oregon — Noridian Admin Svcs (eff. 02/2001/2012)
02402 = Washington — Noridian Admin Svcs (eff. 02/2001/2012)
02831 = WEST CONSORC OCCIDENTAL — ALASKA (term. 07/2002)
02832 = WEST CONSORC OCCIDENTAL — ALASKA (term. 07/2002)
02833 = WEST CONSORC OCCIDENTAL — ALASKA
02835 = WEST CONSORC OCCIDENTAL — ALASKA
00302 = JF Roll-up (2/3) (orig. J3)
003102 = Arizona (eff. 12/1/2006) (replaces carrier #00832)
003202 = Montana (eff. 12/1/2006) (replaces carrier #00751)
003302 = N. Dakota (eff. 12/1/2006) (replaces carrier #00820)
003402 = S. Dakota (eff. 12/1/2006) (replaces carrier #00889)
003502 = Utah (eff. 12/1/2006) (replaces carrier #00823)
003602 = Wyoming (eff. 12/1/2006) (replaces carrier #00825)
004002 = J4 Roll-up
004102 = Colorado (eff. 3/24/08; term.) (replaces carrier #00550)
004112 = Colorado — Novitas Solutions JH (eff. 11/17/2012)
004202 = New Mexico (eff. 3/1/08 (replaces carrier #00521)
004212 = New Mexico — Novitas Solutions JH (eff. 11/17/2012)
004302 = Oklahoma (eff. 3/1/08) (replaces carrier #00522)
004312 = Oklahoma — Novitas Solutions JH (eff. 11/17/2012)
004402 = Texas (eff. 6/2001/08) (replaces carrier #00900)
004412 = Texas — Novitas Solutions JH (eff. 11/17/2012)
005002 = J5 Roll-up
005102 = Iowa (eff 2/1/08) (replaces carrier #00826)
005130 = Idaho — CIGNA (eff. 1983)
005202 = Kansas (eff. 3/1/08) (replaces carrier #00650)
005302 = W. Missouri (eff. 3/1/08) (replaces carrier #00651 or 00740)
005330 = NEW YORK — Equitable
005392 = E. Missouri (eff. 6/1/08) (replaces carrier #00523)
005402 = Nebraska (eff. 3/1/08) (replaces carrier #00655)
005440 = Tennessee — CIGNA (eff. 1983; term. 08/2009) (replaced by MAC #10302)
005535 = North Carolina — CIGNA (eff. 1988)
005655 = DMERC-D Alaska — CIGNA (eff. 1993; term. 09/2006) (replaced by MAC #19003)
006002 = J6 Roll-up
006102 = Illinois
006140 = ILLINOIS — CONTINENTAL CASUALTY (term. 11/2008)
006202 = Minnesota
006302 = Wisconsin
007002 = JH Roll-up (4/7)
007102 = Arkansas — Novitas Solutions JH (eff. 08/11/2012) (CR7812)
007180 = Kentucky — Metropolitan (term. 11/2000)
007202 = Louisiana — Novitas Solutions JH (eff. 08/11/2012)
007302 = Mississippi — Novitas Solutions JH (eff. 10/20/2012)
008002 = J8 Roll-up
008102 = Indiana (eff. 8/20/2012) (replaces carrier #00630)
008190 = Louisiana — Pan American10070 = RRB — UnitedHealthcare (term. 02/2004)
008202 = Michigan (eff. 7/16/2012) (replaces carrier #00953)
009002 = J9 Roll-up
009102 = Florida — First Coast (eff. 02/2009) (replaces carrier #00590)
009202 = Puerto Rico — First Coast (eff. 03/2009) (replaces carrier #00973)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09302</td>
<td>Virgin Island — First Coast (eff. 03/2009) (replaces carrier #00974)</td>
</tr>
<tr>
<td>10002</td>
<td>J10 Roll-up</td>
</tr>
<tr>
<td>10071</td>
<td>RRB — United Healthcare (term. 2000)</td>
</tr>
<tr>
<td>10072</td>
<td>RRB — United Healthcare (term.)</td>
</tr>
<tr>
<td>10074</td>
<td>RRB — United Healthcare (term. 09/2000)</td>
</tr>
<tr>
<td>10102</td>
<td>Alabama (eff. 5/4/09) (replaces carrier #00510)</td>
</tr>
<tr>
<td>10112</td>
<td>Alabama, statewide, all counties — Palmetto GBA</td>
</tr>
<tr>
<td>10202</td>
<td>Georgia (eff. 8/3/09) (replaces carrier #00511)</td>
</tr>
<tr>
<td>10212</td>
<td>Georgia, Atlanta and rest of state — Palmetto GBA</td>
</tr>
<tr>
<td>10230</td>
<td>Connecticut — Metra Health (eff. 1986; term. 2000)</td>
</tr>
<tr>
<td>10240</td>
<td>Minnesota — Metra Health (eff. 1983; term. 08/1994)</td>
</tr>
<tr>
<td>10250</td>
<td>Mississippi — Metra Health (eff. 1983; term. 09/2000)</td>
</tr>
<tr>
<td>10302</td>
<td>Tennessee (eff. 9/1/09) (replaces carrier #05440)</td>
</tr>
<tr>
<td>10312</td>
<td>Tennessee, statewide, all counties — Palmetto GBA</td>
</tr>
<tr>
<td>10490</td>
<td>Virginia — Metra Health (eff. 1983; term. 05/1997)</td>
</tr>
<tr>
<td>10555</td>
<td>DMERC A — United Healthcare (eff. 1993; term. 12/1993)</td>
</tr>
<tr>
<td>11002</td>
<td>J11 Roll-up</td>
</tr>
<tr>
<td>11202</td>
<td>South Carolina — Palmetto Gov. Benefits Admin. (PGBA)</td>
</tr>
<tr>
<td>11302</td>
<td>Virginia (eff. 3/19/2011) Palmetto Gov. Benefits Admin. (PGBA) (replaces carrier #00904)</td>
</tr>
<tr>
<td>11402</td>
<td>West Virginia (eff. 6/18/2011) Palmetto Gov. Benefits Admin. (PGBA)</td>
</tr>
<tr>
<td>12002</td>
<td>J12 Roll-up</td>
</tr>
<tr>
<td>12102</td>
<td>Delaware (eff. 7/11/2008) (replaces carrier #00902)</td>
</tr>
<tr>
<td>12202</td>
<td>District of Columbia (eff. 7/11/2008) (replaces carrier #00903) NOTE: Includes Montgomery &amp; Prince Georges Counties in Maryland; and Fairfax County and the City of Alexandria, VA</td>
</tr>
<tr>
<td>12302</td>
<td>Maryland (eff. 7/11/2008) (replaces carrier #00901)</td>
</tr>
<tr>
<td>12402</td>
<td>New Jersey (eff. 11/14/2008) (replaces carrier #00805)</td>
</tr>
<tr>
<td>12502</td>
<td>Pennsylvania (eff. 12/12/2008) (replaces carrier #00865)</td>
</tr>
<tr>
<td>13002</td>
<td>J13 Roll-up</td>
</tr>
<tr>
<td>13102</td>
<td>Connecticut (eff. 8/1/2008) (replaces carrier #00591)</td>
</tr>
<tr>
<td>13202</td>
<td>East New York (eff. 7/18/2008) (replaces carrier #00803)</td>
</tr>
<tr>
<td>13282</td>
<td>West New York (eff. 9/1/2008) (replaces carrier #00801)</td>
</tr>
<tr>
<td>13292</td>
<td>New York (Queens) (eff. 7/18/2008) (replaces carrier #14330)</td>
</tr>
<tr>
<td>14002</td>
<td>J14 Roll-up</td>
</tr>
<tr>
<td>14102</td>
<td>Maine (eff. 6/1/2009) (replaces carrier #31142)</td>
</tr>
<tr>
<td>14112</td>
<td>Maine, southern Maine and rest of state — National Government Services, Inc.</td>
</tr>
<tr>
<td>14202</td>
<td>Massachusetts (eff. 6/1/2009) (replaces carrier #31143)</td>
</tr>
<tr>
<td>14212</td>
<td>Massachusetts, metro Boston and rest of state — National Government Services, Inc.</td>
</tr>
<tr>
<td>14302</td>
<td>N. Hampshire (eff. 6/1/2009) (replaces carrier #31144)</td>
</tr>
<tr>
<td>14312</td>
<td>New Hampshire, statewide — National Government Services, Inc.</td>
</tr>
<tr>
<td>14330</td>
<td>New York — GHI (eff. 1983; term. 07/2008) (replaced by MAC #13292)</td>
</tr>
<tr>
<td>14402</td>
<td>Rhode Island (eff. 5/1/2009) (replaces carrier #00524)</td>
</tr>
<tr>
<td>14412</td>
<td>Rhode Island, statewide — National Government Services, Inc.</td>
</tr>
<tr>
<td>14502</td>
<td>Vermont (eff. 6/1/2009) (replaces carrier #31145)</td>
</tr>
<tr>
<td>14512</td>
<td>Vermont, statewide — National Government Services, Inc.</td>
</tr>
<tr>
<td>15002</td>
<td>J15 Roll-up</td>
</tr>
<tr>
<td>15102</td>
<td>Kentucky (eff. 4/30/2011) CGS Government Services</td>
</tr>
<tr>
<td>15202</td>
<td>Ohio (eff. 06/15/2011) CGS Government Services</td>
</tr>
</tbody>
</table>
16003 = National Heritage Insurance Company (NHIC) (A) (eff. 7/1/2006) (replaces carrier #00811)  
16013 = CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT — Noridian Healthcare Solutions, LLC (DME MAC)  
16360 = Ohio — Nationwide Insurance Co. (eff. 1983; term. 2002)  
16510 = West Virginia — Nationwide Insurance Co. (eff. 1983; term. 2002)  
17003 = Administer Federal, Inc. (B) (eff. 7/1/2006) (replaces carrier #00635)  
17013 = IL, IN, KY, MI, MN, OH, WI — CGS Administrators, LLC (DME MAC)  
18003 = Connecticut General (CIGNA) (C) (eff. 06/2006) (replaces carrier #00885)  
19003 = Noridian Mutual Ins. Co (D) (eff. 10/1/2006) (replaces carrier #05655)  
31140 = North California — National Heritage Ins. (eff. 1997; term. 08/2008) (replaced by MAC #01102)  
31142 = Maine — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced by MAC #14102)  
31143 = Massachusetts — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced by MAC #14202)  
31144 = New Hampshire — National Heritage Ins. (eff. 1998; term. 05/2009) (replaced by MAC #14302)  
31145 = Vermont — National Heritage Ins. (eff. 1998; term. 05/2009)  
31146 = South California — NHIC (eff. 2000; term. 08/2008)  
66001 = Noridian Competitive Acquisition Program  
80884 = Contractor ID for Physician Risk Adjustment Data (data not sent through NCH, but through Palmetto)  

**COMMENT:** Values and websites referenced may change over time. Refer to this website for current information: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.  

Prior to Version H this field was named: FICARR_IDENT_NUM.
**CARR_PFRNG_PIN_NUM**

**LABEL:** Carrier Line Performing Provider ID Number (PIN)

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

**SHORT NAME:** PRF_PRFL

**LONG NAME:** CARR_PFRNG_PIN_NUM

**TYPE:** CHAR

**LENGTH:** 15

**SOURCE:** NCH

**VALUES:** —

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

[^ Back to TOC ^]
CLAIM_QUERY_CODE

LABEL: Claim Query Code

DESCRIPTION: Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).

SHORT NAME: QUERY_CD

LONG NAME: CLAIM_QUERY_CODE

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = Interim bill
3 = Final bill
5 = Debit adjustment

COMMENT: —
**CLM_ADJUST_GRP_CD**

**LABEL:** Claim Adjustment Group Code

**DESCRIPTION:** Claim adjustment group code used to categorize a payment adjustment for a claim or claim line. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

**SHORT NAME:** CLM_ADJUST_GRP_CD

**LONG NAME:** CLM_ADJUST_GRP_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**
- CO = Contractual obligation
- OA = Other adjustment
- PR = Patient responsibility

**COMMENT:** This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.

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**CLM_ADJUST_RSN_CD**

**LABEL:** Claim Adjustment Reason Code

**DESCRIPTION:** Claim Adjustment Reason Code used to describe why a claim or claim line was paid differently than billed. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

**SHORT NAME:** CLM_ADJUST_RSN_CD

**LONG NAME:** CLM_ADJUST_RSN_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** This is not a comprehensive list of values; refer to website below for current values and descriptions:
- 96 = Non-covered charge(s). At least one Remark Code must be provided
- 119 = Benefit maximum for this time period or occurrence has been reached
- B9 = Patient is enrolled in a hospice

**COMMENT:** This code set is an external code set maintained by X12 [www.x12.org/codes](http://www.x12.org/codes). This field is not populated prior to 2021.
**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. When this variable appears in the HHA claims (Short Name = HHSTRTDT), it is the date the care began for the HHA services reported on the claim.

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.

**SHORT NAME:** ADMSN_DT

**LONG NAME:** CLM_ADMSN_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** In HHA claims, this is the date the home health plan was established or last reviewed.

This field is not well populated in HHA until after 2011.
**CLM_BASE_OPRTG_DRG_AMT**

**LABEL:** Claim Base Operating DRG Amount

**DESCRIPTION:** The amount of the wage adjusted DRG operating payment plus the technology add-on payment.

**SHORT NAME:** CLM_BASE_OPRTG_DRG_AMT

**LONG NAME:** CLM_BASE_OPRTG_DRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** This variable was new in 2011.

It is populated only for inpatient claims.
**CLM_BENE_ID>Type_CD**

**LABEL:** Claim Beneficiary Identifier Type Code

**DESCRIPTION:** This field identifies whether the claim was submitted by the provider, during the transition period, with a HICN or MBI (For CMS Internal Use).

**SHORT NAME:** CLM_BENE_ID_TYPE_CD

**LONG NAME:** CLM_BENE_ID_TYPE_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- M = MBI
- H = HICN
- Null/missing

**COMMENT:** This field is populated for CMS Internal Use. It was new in 2017.
**CLM_BENE_PD_AMT**

**LABEL:** Carrier Claim Beneficiary Paid Amount

**DESCRIPTION:** The amount paid by the beneficiary for the non-institutional Part B (carrier, or DMERC) claim.

**SHORT NAME:** CLM_BENE_PD_AMT

**LONG NAME:** CLM_BENE_PD_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** —
**CLM_BNDLD_ADJSTMT_PMT_AMT**

**LABEL:** Claim Bundled Adjustment Payment Amount

**DESCRIPTION:** This field represents the amount the claim was reduced for those hospitals participating in Model 1 of the Bundled Payments for Care Improvement initiative (BPCI, Model 1).

**SHORT NAME:** CLM_BNDLD_ADJSTMT_PMT_AMT

**LONG NAME:** CLM_BNDLD_ADJSTMT_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** The hospital must be participating in the Model 1 of the Bundled Payments for Care Improvement initiative (refer to CLM_CARE_IMPRVMT_MODEL_CD1). The percentage of the discount that this amount represents is in the field called CLM_BNDLD_MODEL_1_DSCNT_PCT.

This field was new in 2013 and is null/missing for all previous years.

[^ Back to TOC ^]
**CLM_BNDLD_MODEL_1_DSCNT_PCT**

**LABEL:** Claim Bundled Model 1 Discount Percent

**DESCRIPTION:** This field identifies the discount percentage which will be applied to payment for all participating hospitals' DRG over the lifetime of the Bundled Payments for Care Improvement initiative (BPCI, Model 1).

**SHORT NAME:** CLM_BNDLD_MODEL_1_DSCNT_PCT

**LONG NAME:** CLM_BNDLD_MODEL_1_DSCNT_PCT

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** X.XX

**COMMENT:** The hospital must be participating in the Model 1 of the BPCI (refer to CLM_CARE_IMPRVMT_MODEL_CD1). The dollar amount of the payment reduction for the service is in the field called CLM_BNDLD_ADJSTMT_PMT_AMT.

This field was new in 2013 and is null/missing for all previous years.
**CLM_CARE_IMPRVMT_MODEL_CD1**

**CLM_CARE_IMPRVMT_MODEL_CD2**

**CLM_CARE_IMPRVMT_MODEL_CD3**

**CLM_CARE_IMPRVMT_MODEL_CD4**

**LABEL:** Claim Care Improvement Model Code (bundled payment)

**DESCRIPTION:** This code is used to identify the care improvement model being used for bundling payments. The initiative if referred to as the Bundled Payments for Care Improvement initiative (BPCI).

**SHORT NAME:**

CLM_CARE_IMPRVMT_MODEL_CD1  CLM_CARE_IMPRVMT_MODEL_CD3
CLM_CARE_IMPRVMT_MODEL_CD2  CLM_CARE_IMPRVMT_MODEL_CD4

**LONG NAME:**

CLM_CARE_IMPRVMT_MODEL_CD1  CLM_CARE_IMPRVMT_MODEL_CD3
CLM_CARE_IMPRVMT_MODEL_CD2  CLM_CARE_IMPRVMT_MODEL_CD4

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

61 = Care Improvement Model 1 is used
62 = Care Improvement Model 2 is used
63 = Care Improvement Model 3 is used
64 = Care Improvement Model 4 is used
Null/missing

**COMMENT:** There are 4 of these Care Improvement Model fields (CLM_CARE_IMPRVMT_MODEL_CD1–CLM_CARE_IMPRVMT_MODEL_CD4). This field was new in 2013 and is null/missing for all previous years.
**CLM_CLNCL_TRIL_NUM**

**LABEL:** Clinical Trial Number

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

**SHORT NAME:** CCLTRNUM

**LONG NAME:** CLM_CLNCL_TRIL_NUM

**TYPE:** CHAR

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** CMS is requesting the clinical trial number be voluntarily reported. The number is assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered. Effective September 1, 2008, with the implementation of CR#3.

^ Back to TOC ^
**CLM_DISP_CD**

**LABEL:** Claim Disposition Code

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

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

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

**SHORT NAME:** DISP_CD

**LONG NAME:** CLM_DISP_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**
- 01 = Debit accepted

**COMMENT:** —

[^ Back to TOC ^]
**CLM_DRG_CD**

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

**DESCRIPTION:** The diagnostic related group to which a hospital claim belongs for prospective payment purposes.

**SHORT NAME:** DRG_CD

**LONG NAME:** CLM_DRG_CD

**TYPE:** CHAR

**LENGTH:** 4

**SOURCE:** NCH

**VALUES:** –

**COMMENT:** Starting in January 2021 with NCH version L, this field changed from 3 characters to 4.

GROUPER is the software that determines the DRG from data elements reported by the hospital.

Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment.

Nonpayment claims (zero reimbursement) may not have a DRG present.
**CLM_DRG_OUTLIER_STAY_CD**

**LABEL:** Claim Diagnosis Related Group Outlier Stay Code

**DESCRIPTION:** On an institutional claim, the code that indicates the beneficiary stay under the prospective payment system (PPS) which, although classified into a specific diagnosis related group, has an unusually long length (day outlier) or exceptionally high cost (cost outlier).

**SHORT NAME:** OUTLR_CD

**LONG NAME:** CLM_DRG_OUTLIER_STAY_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
0 = No outlier
1 = Day outlier (condition code 60)
2 = Cost outlier (condition code 61)

*** Non-PPS Only ***
6 = Valid diagnosis related groups (DRG) received from the intermediary
7 = CMS developed DRG
8 = CMS developed DRG using patient status code
9 = Not groupable

**COMMENT:** —
**LABEL:** Claim Diagnosis E Code Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis E codes (principal and secondary).

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.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**SHORT NAME:**

<table>
<thead>
<tr>
<th>CLM_E_POA_IND_SW1</th>
<th>CLM_E_POA_IND_SW7</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM_E_POA_IND_SW2</td>
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<tr>
<td>CLM_E_POA_IND_SW5</td>
<td>CLM_E_POA_IND_SW11</td>
</tr>
<tr>
<td>CLM_E_POA_IND_SW6</td>
<td>CLM_E_POA_IND_SW12</td>
</tr>
</tbody>
</table>

**LONG NAME:**

<table>
<thead>
<tr>
<th>CLM_E_POA_IND_SW1</th>
<th>CLM_E_POA_IND_SW7</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>CLM_E_POA_IND_SW3</td>
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</tr>
<tr>
<td>CLM_E_POA_IND_SW6</td>
<td>CLM_E_POA_IND_SW12</td>
</tr>
</tbody>
</table>

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

<table>
<thead>
<tr>
<th>Y = Diagnosis was present at the time of admission (POA)</th>
<th>N = Diagnosis was not present at the time of admission</th>
</tr>
</thead>
</table>
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

X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future.

Z = Denotes the end of the POA indicators

1 = Unreported/not used — exempt from POA reporting — this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data.

COMMENT: Medicare claims did not indicate whether a diagnosis was POA until 2011.
**CLM_FAC_TYPE_CD**

**LABEL:** Claim Facility Type Code

**DESCRIPTION:** The type of facility.

**SHORT NAME:** FAC_TYPE

**LONG NAME:** CLM_FAC_TYPE_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- 1 = Hospital
- 2 = Skilled nursing facility (SNF)
- 3 = Home health agency (HHA)
- 4 = Religious Non-medical (hospital)
- 6 = Intermediate Care (IMC)
- 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).
**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:** FREQ_CD

**LONG NAME:** CLM_FREQ_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 0 = Non-payment/zero claims
- 1 = Admit thru discharge claim
- 2 = Interim — first claim
- 3 = Interim — continuing claim
- 4 = Interim — last claim
- 5 = Late charge(s) only claim
- 7 = Replacement of prior claim
- 8 = Void/cancel prior claim
- 9 = Final claim (for HH PPS = process as a debit/credit to RAP claim)
- G = Common Working File (NCH) generated adjustment claim
- H = CMS generated adjustment claim
- I = Misc. adjustment claim (e.g., initiated by intermediary or QIO)
- J = Other adjustment request
- K = OIG Initiated Adjustment Claim
- M = Medicare secondary payer (MSP) adjustment
- P = Adjustment required by QIO
- Q = Claim Submitted for Reconsideration Outside of Timely Limits

**COMMENT:** This field can be used in determining the “type of bill” for an institutional claim. Often 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, and it is helpful for distinguishing between final, interim, or RAP (request for anticipated payment) claims — which is particularly helpful if you receive claims that are not “final action.”

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 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).
**CLM_FROM_DT**

**LABEL:** Claim From Date

**DESCRIPTION:** The first day on the billing statement covering services rendered to the beneficiary (aka “Statement Covers From Date”).

**SHORT NAME:** FROM_DT

**LONG NAME:** CLM_FROM_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** For home health prospective payment system (PPS) claims, the 'from' date and the 'thru' date on the RAP (request for anticipated payment) initial claim must always match.

The "from" date on the claim may not always represent the first date of services, particularly for home health or hospice care. To obtain the date corresponding with the onset of services (or admission date) use the admission date from the claim (variable called CLM_ADMSN_DT for IP, SNF, and HH — and variable called CLM_HOSPC_START_DT_ID for hospice claims).

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

**LABEL:** Claim Full Standard Payment Amount

**DESCRIPTION:** This variable is the standard payment amount for long-term care hospitals (LTCH) under the Medicare prospective payment system (PPS), which is based on the MS-LTC-DRG.

This amount does not include any applicable outlier payment amount.

**SHORT NAME:** CLM_FULL_STD_PYMT_AMT

**LONG NAME:** CLM_FULL_STD_PYMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Applies only to inpatient (LTCH) claims. This field is new in October 2015.

For a LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the four fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.
**CLM_HHA_LUPA_IND_CD**

**LABEL:** Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code

**DESCRIPTION:** The code used to identify those home health PPS claims that have 4 visits or less in a 60-day episode.

If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of home health resource groups (HHRGs).

**SHORT NAME:** LUPAIND

**LONG NAME:** CLM_HHA_LUPA_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- L = Low utilization payment adjustment (LUPA) claim
- Blank = Not a LUPA claim; process using home health resource groups (HHRG)

**COMMENT:** Beginning 10/1/2000, this field was populated with data. Claims processed prior to 10/1/2000 contained spaces.
**CLM_HHA_RFRL_CD**

**LABEL:** Claim HHA Referral Code

**DESCRIPTION:** Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for home health services.

**SHORT NAME:** HHA_RFRL

**LONG NAME:** CLM_HHA_RFRL_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

1 = Physician referral — the patient was admitted upon the recommendation of a personal physician.

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

3 = HMO referral — the patient was admitted upon the recommendation of a health maintenance organization (HMO) physician.

4 = Transfer from hospital — the patient was admitted as an inpatient transfer from an acute care facility.

5 = Transfer from a skilled nursing facility (SNF) — the patient was admitted as an inpatient transfer from a SNF.

6 = Transfer from another health care facility — the patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.

7 = Emergency room — the patient was admitted upon the recommendation of this facility's emergency room physician.

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

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

A = Transfer from a Critical Access Hospital — patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

B = Transfer from another HHA — beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff.10/2000).

C = Readmission to same HHA — if a beneficiary is discharged from an HHA and then readmitted within the original 60-day episode, the original episode must be closed early and a new one created.

D = Unknown/invalid code.
COMMENT: The use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/2000)

Beginning 10/1/2000, this field was populated with data. Claims processed prior to 10/1/2000 contained spaces in this field.
**CLM_HHA_TOT_VISIT_CNT**

**LABEL:** Claim HHA Total Visit Count

**DESCRIPTION:** The count of the number of HHA visits as derived by CMS.

**SHORT NAME:** VISITCNT

**LONG NAME:** CLM_HHA_TOT_VISIT_CNT

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** Derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X, and 059X). Value 999 will be displayed if the sum of the revenue center unit count equals or exceeds 999.

Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15-minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.
**CLM_HOSPC_START_DT_ID**

**LABEL:** Claim Hospice Start Date

**DESCRIPTION:** On an institutional claim, the date the beneficiary was admitted to the hospice care.

**SHORT NAME:** HSPCSTRT

**LONG NAME:** CLM_HOSPC_START_DT_ID

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
### CLM_HRR_ADJSTMT_PCT

**LABEL:** Claim HRR Adjustment Percent  

**DESCRIPTION:** Under the Hospital Readmissions Reduction (HRR) Program, the amount used to identify the readmission adjustment factor that will be applied.  

**SHORT NAME:** CLM_HRR_ADJSTMT_PCT  

**LONG NAME:** CLM_HRR_ADJSTMT_PCT  

**TYPE:** NUM  

**LENGTH:** 8  

**SOURCE:** NCH  

**VALUES:** X.XXXX  

**COMMENT:** The ACA (Section 3025) requires CMS to reduce payments to subsection (d) inpatient prospective payment system (IPPS) hospitals with excess readmissions. There is a variable that indicates whether the hospital was excluded from the HRR program (reference CLM_HRR_PRTCPNT_IND_CD). This percentage reduction is applied to the base operating DRG amount (defined as the wage adjusted DRG payment plus new technology add-on payments).  

Additional information is available on the CMS "Hospital Value-Based Purchasing" website.  

The actual dollar amount of the adjustment that applied to the claim is found in the variable called CLM_HRR_ADJSTMT_PMT_AMT.  

This initiative began in fourth quarter of 2012 (e.g., beginning of federal fiscal year 13).  

This field was new in 2012 and is null/missing for all previous years.
**CLM_HRR_ADJSTMT_PMT_AMT**

**LABEL:** Claim Hospital Readmission Reduction (HRR) Adjustment Payment Amount

**DESCRIPTION:** This field represents the Hospital Readmission Reduction (HRR) Program Payment Amount. The amount is the reduction to the claim for a readmission.

**SHORT NAME:** CLM_HRR_ADJSTMT_PMT_AMT

**LONG NAME:** CLM_HRR_ADJSTMT_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX (may be a negative value)

**COMMENT:**

The ACA (Section 3025) requires CMS to reduce payments to subsection (d) inpatient prospective payment system (IPPS) hospitals with excess readmissions. There is a variable that indicates whether the hospital was excluded from the HRR program (reference CLM_HRR_PRTCPNT_IND_CD). This percentage reduction is applied to the base operating DRG amount (defined as the wage adjusted DRG payment plus new technology add-on payments).

Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

This amount is based on a percent (CLM_HRR_ADJSTMT_PCT).

This initiative began in fourth quarter of 2012 (i.e., beginning of federal fiscal year 13).

This field was new in 2012 and is null/missing for all previous years.

[^ Back to TOC ^]
**CLM_HRR_PRTCPNT_IND_CD**

**LABEL:** Claim Hospital Readmission Reduction (HRR) Participant Indicator Code

**DESCRIPTION:** This field is the code used to identify whether the hospital is participating in the Hospital Readmissions Reduction (HRR) program.

**SHORT NAME:** CLM_HRR_PRTCPNT_IND_CD

**LONG NAME:** CLM_HRR_PRTCPNT_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- 0 = Not participating
- 1 = Participating and not equal to 1.0000
- 2 = Participating and equal to 1.0000
- Null/missing = Not participating

**COMMENT:**

The ACA (Section 3025) requires CMS to reduce payments to inpatient prospective payment system (IPPS) hospitals with excess readmissions.

Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

This initiative began in fourth quarter of 2012 (i.e., beginning of federal fiscal year 13).

This field was new in 2012 and is null/missing for all previous years.
**CLM_ID**

**LABEL:** Claim ID

**DESCRIPTION:** This is the unique identification number for the claim.

Each Part A or institutional Part B claim has at least one revenue center record.

Each non-institutional Part B claim has at least one claim line.

All revenue center records or claim lines on a given claim have the same CLM_ID. It is used to link the revenue lines together and/or to the base claim.

**SHORT NAME:** CLM_ID

**LONG NAME:** CLM_ID

**TYPE:** CHAR

**LENGTH:** 15

**SOURCE:** CCW

**VALUES:** —

**COMMENT:** The CLM_ID is assigned by the CCW. The CLM_ID is specific to the CCW and is not applicable to any other identification system or data source.

Limitation: When pulled directly from the CCW database, this is a numeric column.
**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:** TYPE_ADM

**LONG NAME:** CLM_IP_Admsn_Type_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
0 = Unknown Value (but present in data)
1 = Emergency — the patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2 = Urgent — the patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
3 = Elective — the patient's condition permitted adequate time to schedule the availability of suitable accommodations.
4 = Newborn — necessitates the use of special source of admission codes.
5 = Trauma center — visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
6 = Reserved
7 = Reserved
8 = Reserved
9 = Unknown — information not available.

**COMMENT:** —
**CLM_IP_INITL_MS_DRG_CD**

**LABEL:** Claim Inpatient Initial MS DRG Code

**DESCRIPTION:** Claim inpatient Initial MS Diagnosis Related Group (DRG) Code

**SHORT NAME:** CLM_IP_INITL_MS_DRG_CD

**LONG NAME:** CLM_IP_INITL_MS_DRG_CD

**TYPE:** CHAR

**LENGTH:** 4

**SOURCE:** NCH

**VALUES:** XXXX

**COMMENT:** This field identifies the initial MS-DRG code assigned by MS-DRG Grouper prior to application of Hospital Acquired Conditions (HAC) logic. The data will only be populated on inpatient claims. Data will not start coming in until July 2019.
**CLM_IP_LOW_VOL_PMT_AMT**

**LABEL:** Claim Inpatient Low Volume Payment Amount

**DESCRIPTION:** This is the amount field used to identify a payment adjustment given to hospitals to account for the higher costs per discharge for low-income hospitals under the inpatient prospective payment system (IPPS).

**SHORT NAME:** CLM_IP_LOW_VOL_PMT_AMT

**LONG NAME:** CLM_IP_LOW_VOL_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Payment adjustment for low income IPPS hospitals.

This field was new in 2011.
**CLM_LINE_NUM**

**LABEL:** Claim Line Number

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

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

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

**SHORT NAME:** CLM_LN

**LONG NAME:** CLM_LINE_NUM

**TYPE:** NUM

**LENGTH:** 13

**SOURCE:** CCW

**VALUES:** —

**COMMENT:** —
<table>
<thead>
<tr>
<th><strong>CLM_MCO_PD_SW</strong></th>
<th></th>
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<tbody>
<tr>
<td><strong>LABEL:</strong></td>
<td>Claim MCO Paid Switch</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong></td>
<td>MCOPDSW</td>
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<td>CLM_MCO_PD_SW</td>
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<tr>
<td><strong>SOURCE:</strong></td>
<td>NCH</td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
<td>Blank = No managed care organization (MCO) payment 0 = No managed care organization (MCO) payment 1 = MCO paid provider for the claim</td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
<td>—</td>
</tr>
</tbody>
</table>
**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.

**SHORT NAME:** CLM_MDCL_REC

**LONG NAME:** CLM_MDCL_REC

**TYPE:** CHAR

**LENGTH:** 17

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** This variable may be null/missing.
**CLM_MDCR_NON_PMT_RSN_CD**

**LABEL:** Claim Medicare Non-Payment Reason Code

**DESCRIPTION:** The reason that no Medicare payment is made for services on an institutional claim.

**SHORT NAME:** NOPAY_CD

**LONG NAME:** CLM_MDCR_NON_PMT_RSN_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- A = Covered worker's compensation (Obsolete)
- B = Benefit exhausted
- C = Custodial care — non-covered care (includes all 'beneficiary at fault' waiver cases) (Obsolete)
- E = HMO out-of-plan services not emergency or urgently needed (Obsolete)
- E = MSP cost avoided — IRS/SSA/HCFA Data Match (eff. 7/2000)
- F = MSP cost avoids HMO Rate Cell (eff. 7/2000)
- G = MSP cost avoided Litigation Settlement (eff. 7/2000)
- H = MSP cost avoided Employer Voluntary Reporting (eff. 7/2000)
- J = MSP cost avoids Insurer Voluntary Reporting (eff. 7/2000)
- K = MSP cost avoids Initial Enrollment Questionnaire (eff. 7/2000)
- N = All other reasons for non-payment
- P = Payment requested
- Q = MSP cost avoided Voluntary Agreement (eff. 7/2000)
- R = Benefits refused, or evidence not submitted
- U = MSP cost avoided — HMO rate cell adjustment (eff. 9/1976) (Obsolete 6/30/2000)
- V = MSP cost avoided — litigation settlement (eff. 9/1976) (Obsolete 6/30/2000)
- W = Worker's compensation (Obsolete)
- X = MSP cost avoided — generic
- Y = MSP cost avoided — IRS/SSA data match project (obsolete 6/30/2000)
- Z = Zero reimbursement RAPs — zero reimbursement made due to medical review intervention or where provider specific zero payment has been determined. (eff. with HHPPS — 10/2000)
- 00 = MSP cost avoided — COB Contractor
- 12 = MSP cost avoided — BCBS Voluntary Agreements
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>MSP cost avoided — Office of Personnel Management</td>
</tr>
<tr>
<td>14</td>
<td>MSP cost avoided — Workman’s Compensation (WC) Datamatch</td>
</tr>
<tr>
<td>15</td>
<td>MSP cost avoided — Workman’s Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)</td>
</tr>
<tr>
<td>16</td>
<td>MSP cost avoided — Liability Insurer VDSA (eff. 4/2006)</td>
</tr>
<tr>
<td>17</td>
<td>MSP cost avoided — No-Fault Insurer VDSA (eff. 4/2006)</td>
</tr>
<tr>
<td>18</td>
<td>MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006)</td>
</tr>
<tr>
<td>19</td>
<td>REFERENCE NOTE4: Coordination of Benefits Contractor 11119 (reference CMS Change Request 7906 for identification of the contractor.)</td>
</tr>
<tr>
<td>21</td>
<td>MSP cost avoided — MIR Group Health Plan (eff. 1/2009)</td>
</tr>
<tr>
<td>22</td>
<td>MSP cost avoided — MIR non-Group Health Plan (eff. 1/2009)</td>
</tr>
<tr>
<td>25</td>
<td>MSP cost avoided — Recovery Audit Contractor — California (eff. 10/2005)</td>
</tr>
<tr>
<td>26</td>
<td>MSP cost avoided — Recovery Audit Contractor — Florida (eff. 10/2005)</td>
</tr>
<tr>
<td>42</td>
<td>REFERENCE NOTE4: Coordination of Benefits Contractor 11142 (reference CMS Change Request 7906 for identification of the contractor.)</td>
</tr>
<tr>
<td>43</td>
<td>REFERENCE NOTE4: Coordination of Benefits Contractor 11143 (reference CMS Change Request 7906 for identification of the contractor.)</td>
</tr>
</tbody>
</table>

Effective 4/1/2002, the Medicare nonpayment reason code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH and NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>!</td>
<td>MSP cost avoided — COB Contractor (‘00’ 2-byte code)</td>
</tr>
<tr>
<td>@</td>
<td>MSP cost avoided — BC/BS Voluntary Agreements (‘12’ 2-byte code)</td>
</tr>
<tr>
<td>#</td>
<td>MSP cost avoided — Office of Personnel Management (‘13’ 2-byte code)</td>
</tr>
<tr>
<td>$</td>
<td>MSP cost avoided — Workman’s Compensation (WC) Datamatch (‘14’ 2-byte code)</td>
</tr>
<tr>
<td>*</td>
<td>MSP cost avoided — Workman’s Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (‘15’ 2-byte code) (eff. 4/2006)</td>
</tr>
<tr>
<td>(</td>
<td>MSP cost avoided — Liability Insurer VDSA (‘16’ 2-byte code) (eff. 4/2006)</td>
</tr>
<tr>
<td>)</td>
<td>MSP cost avoided — No-Fault Insurer VDSA (‘17’ 2-byte code) (eff. 4/2006)</td>
</tr>
<tr>
<td>+</td>
<td>MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (‘18’ 2-byte code) (eff. 4/2006)</td>
</tr>
<tr>
<td>&lt;</td>
<td>MSP cost avoided — MIR Group Health Plan (‘21’ 2-byte code) (eff. 1/2009)</td>
</tr>
<tr>
<td>&gt;</td>
<td>MSP cost avoided — MIR non-Group Health Plan (‘22’ 2-byte code) (eff. 1/2009)</td>
</tr>
</tbody>
</table>
% = MSP cost avoided — Recovery Audit Contractor — California ('25' 2-byte code) (eff. 10/2005)
& = MSP cost avoided — Recovery Audit Contractor — Florida ('26' 2-byte code) (eff. 10/2005)

**COMMENT:** This field was put on all institutional claim types, but data did not start coming in on OP/HHA/hospice until 4/1/2002. Prior to 4/1/2002, data only came in inpatient/SNF claims.

Effective 4/1/2002, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. Reference table of code for the crosswalk.

**NOTE:** Effective with Version ‘J,’ the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two-byte values being sent in by NCH since 4/2002.

During the Version 'J' conversion, all character values were converted to the two-byte values.
**CLM_MODEL_4_READMSN_IND_CD**

**LABEL:** Claim Model 4 Readmission Indicator Code

**DESCRIPTION:** This field identifies the method of payment of a claim billed within 30 days of a Model 4 Bundled Payments for Care Improvement (BPCI) admission.

**SHORT NAME:** CLM_MODEL_4_READMSN_IND_CD

**LONG NAME:** CLM_MODEL_4_READMSN_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

1 = claim is related readmission to a Model 4 BPCI claim and shall pay IME, DSH, and Capital Only.

2 = two Model 4 BPCI claims within 30 days of each other, first claim in episode shall process as it would in the absence of Model 4 BPCI.

3 = two Model 4 BPCI claims within 30 days of each other, this is the second claim in the episode and paid as Model 4.

Null/missing = not a BPCI claim

**COMMENT:** Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients. Under the Model 4 BPCI pilot, CMS will reimburse qualified acute care hospitals a blended payment for hospital inpatient care and physician services connected with a single episode of care. This will occur in association with inpatient hospital claims that the BPCI participating hospital will bill to their jurisdictional A/B MAC as type of bill 11X claims.
**CLM_MODEL_REIMBRSMNT_AMT**

**LABEL:** Claim Model Reimbursement Amount

**DESCRIPTION:** This field is used to identify the “net reimbursement amount” of what Medicare would have paid for global budget services from a hospital participating in the particular model. If the claim only includes global services, the reimbursement amount (CLM_PMT_AMT) will reflect $0. If the claim includes global and non-global services, the reimbursement amount will reflect the amount Medicare actually paid for the non-global services.

**SHORT NAME:** CLM_MODEL_REIMBRSMNT_AMT

**LONG NAME:** CLM_MODEL_REIMBRSMNT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**COMMENT:** This field is new in January 2020. This field only applies to Part A claims.

This model reimbursement amount applies to the Pennsylvania Rural Health Model (PARHM) (CR11355). A demo code (variable called DEMO_ID_NUM) will be assigned for future models. CLM_RLT_COND_CD = M6 (on the occurrence code file) and CLM_VAL_CD = Q4 (on the value code file) have been created to identify the PARH model.

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**CLM_NEXT_GNRTN_ACO_IND_CD1**

**CLM_NEXT_GNRTN_ACO_IND_CD2**

**CLM_NEXT_GNRTN_ACO_IND_CD3**

**CLM_NEXT_GNRTN_ACO_IND_CD4**

**CLM_NEXT_GNRTN_ACO_IND_CD5**

**LABEL:** Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code

**DESCRIPTION:** The field identifies the claims that qualify for specific claims processing edits related to benefit enhancement through the Next Generation (NG) Accountable Care Organization (ACO).

**SHORT NAME:**

- CLM_NEXT_GNRTN_ACO_IND_CD1
- CLM_NEXT_GNRTN_ACO_IND_CD2
- CLM_NEXT_GNRTN_ACO_IND_CD3
- CLM_NEXT_GNRTN_ACO_IND_CD4
- CLM_NEXT_GNRTN_ACO_IND_CD5

**LONG NAME:**

- CLM_NEXT_GNRTN_ACO_IND_CD1
- CLM_NEXT_GNRTN_ACO_IND_CD2
- CLM_NEXT_GNRTN_ACO_IND_CD3
- CLM_NEXT_GNRTN_ACO_IND_CD4
- CLM_NEXT_GNRTN_ACO_IND_CD5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- 0 = Base record (no enhancements)
- 1 = Population Based Payments (PBP)
- 2 = Telehealth
- 3 = Post Discharge home health Visits
- 4 = 3-Day SNF Waiver
- 5 = Capitation
- 6 = CEC Telehealth
- 7 = Care Management Home Visits
- 8 = Primary Care Capitation (PCC)
- 9 = Home health Benefit Enhancement — eff. 4/2021
- B = Concurrent Care for Beneficiaries that Elect the Medicare hospice Benefit — eff. 4/2021
- C = Kidney Disease Education (KDE) — eff. 4/2021
- D = Seriously Ill Population (SIP)
- E = Flat Visit Fee (FVF)
- F = Quarterly Capitation Payment (QCP) — eff. 4/2021
- G = Performance Based Adjustment (PBA) — eff. 7/2022

**COMMENT:** —
**CLM_NON_UTLZTN_DAYS_CNT**

**LABEL:** Claim Medicare Non-Utilization Days Count

**DESCRIPTION:** On an institutional claim, the number of days of care that are not chargeable to Medicare facility utilization.

**SHORT NAME:** NUTILDAY

**LONG NAME:** CLM_NON_UTLZTN_DAYS_CNT

**TYPE:** NUM

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
<table>
<thead>
<tr>
<th><strong>CLM_OP_BENE_PMT_AMT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
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<tr>
<td><strong>SHORT NAME:</strong></td>
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<tr>
<td><strong>LONG NAME:</strong></td>
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<td><strong>TYPE:</strong></td>
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<td><strong>LENGTH:</strong></td>
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<tr>
<td><strong>SOURCE:</strong></td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
</tr>
</tbody>
</table>
**CLM_OP_ESRD_MTHD_CD**

**LABEL:** Claim Outpatient End-stage Renal Disease (ESRD) Method of Reimbursement Code

**DESCRIPTION:** This variable contains the code denoting the method of reimbursement selected by the beneficiary receiving End-stage Renal Disease (ESRD) services for home dialysis (i.e., whether home supplies are purchased through a facility or from a supplier.)

**SHORT NAME:** CLM_OP_ESRD_MTHD_CD

**LONG NAME:** CLM_OP_ESRD_MTHD_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- 0 = Not ESRD
- 1 = Method 1 — Home supplies purchased through a facility
- 2 = Method 2 — Home supplies purchased from a supplier

**COMMENT:** —
**CLM_OP_PPS_IND**

**LABEL:** Claim Outpatient prospective payment system (OPPS) Indicator

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

**SHORT NAME:** CLM_OP_PPS_IND

**LONG NAME:** CLM_OP_PPS_IND

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- 1 = OPPS
- 2 = Non-OPPS

**COMMENT:** A blank, zero or any other value is defaulted to 1. This field is not populated prior to 2021.
**CLM_OP_PRVDR_PMT_AMT**

**LABEL:** Claim Outpatient Provider Payment Amount

**DESCRIPTION:** The amount paid, from the Medicare trust fund, to the provider for the services reported on the outpatient claim.

**SHORT NAME:** PRVDRPMT

**LONG NAME:** CLM_OP_PRVDR_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** —
**CLM_OP_TRANS_TYPE_CD**

**LABEL:** Claim Outpatient transaction type

**DESCRIPTION:** The code derived by CMS based on the type of bill and provider number to identify the outpatient transaction type.

**SHORT NAME:** CLM_OP_TRANS_TYPE_CD

**LONG NAME:** CLM_OP_TRANS_TYPE_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- A = Outpatient Psychiatric hospital
- B = Outpatient tuberculosis (TB) hospital
- C = Outpatient General Care hospital
- D = Outpatient skilled nursing facility (SNF)
- E = Home health agency
- F = Comprehensive Health Care
- G = Clinical Rehab agency
- H = Rural Health Clinic
- I = Satellite Dialysis Facility
- J = Limited Care Facility
- 0 = Christian Science SNF
- 1 = Psychiatric hospital Facility
- 2 = TB hospital Facility
- 3 = General Care hospital
- 4 = Regular SNF
- Spaces = Home health/hospice

**COMMENT:** —
**CLM_PASS_THRU_PER_DIEM_AMT**

**LABEL:** Claim Pass Thru Per Diem Amount

**DESCRIPTION:** Medicare establishes a daily payment amount to reimburse IPPS hospitals for certain “pass-through” expenses, such as capital-related costs, direct medical education costs, kidney acquisition costs for hospitals that are renal transplant centers, and bad debts. This variable is the daily payment rate for pass-through expenses. It is not included in the CLM_PMT_AMT field.

To determine the total of the pass-through payments for a hospitalization, this field should be multiplied by the claim Medicare utilization day count (CLM_UTLZTN_DAY_CNT). Then, total Medicare payments for a hospitalization claim can be determined by summing this product and the CLM_PMT_AMT field.

**SHORT NAME:** PER_DIEM

**LONG NAME:** CLM_PASS_THRU_PER_DIEM_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” Reference: and also in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” Reference the list of MLN publications at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospice
**CLM_PMT_AMT**

**LABEL:** Claim (Medicare) Payment Amount

**DESCRIPTION:** The Medicare claim payment amount.

For hospital services, this amount does not include the claim pass-through per diem payments made by Medicare. To obtain the total amount paid by Medicare for the claim, the pass-through amount (which is the daily per diem amount) must be multiplied by the number of Medicare-covered days (e.g., multiply the CLM_PASS_THRU_PER_DIEM_AMT by the CLM_UTLZTN_DAY_CNT), and then added to the claim payment amount (this field).

For non-hospital services (SNF, home health, hospice, and hospital outpatient) and for other non-institutional services (Carrier and DME), this variable equals the total actual Medicare payment amount, and pass-through amounts do not apply.

For Part B non-institutional services (Carrier and DME), this variable equals the sum of all the line item-level Medicare payments (variable called the LINE_NCH_PMT_AMT).

**SHORT NAME:** PMT_AMT

**LONG NAME:** CLM_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/)).

**LABEL:** Claim Diagnosis Code Present on Admission (POA) Indicator Code

**DESCRIPTION:** The present on admission (POA) indicator code associated with the diagnosis codes (principal and secondary).

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.

Medicare claims did not indicate whether a diagnosis was POA until 2011.

**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_SW14
CLM_POA_IND_SW2   CLM_POA_IND_SW15
CLM_POA_IND_SW3   CLM_POA_IND_SW16
CLM_POA_IND_SW4   CLM_POA_IND_SW17
CLM_POA_IND_SW5   CLM_POA_IND_SW18
CLM_POA_IND_SW6   CLM_POA_IND_SW19
CLM_POA_IND_SW7   CLM_POA_IND_SW20
CLM_POA_IND_SW8   CLM_POA_IND_SW21
CLM_POA_IND_SW9   CLM_POA_IND_SW22
CLM_POA_IND_SW10  CLM_POA_IND_SW23
CLM_POA_IND_SW11  CLM_POA_IND_SW24
CLM_POA_IND_SW12  CLM_POA_IND_SW25
CLM_POA_IND_SW13

TYPE: CHAR
LENGTH: 1
SOURCE: NCH
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
        1 = Unreported/not used — exempt from POA reporting — this code is the equivalent code of a blank, however, it was determined that blanks were undesirable when submitting the data
        Z = Denotes the end of the POA indicators
        X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future

COMMENT: Prior to Version 'J,' the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM_POA_IND_CD. Medicare claims did not indicate whether a diagnosis was POA until 2011.

The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.
CLM_PPS_CPTL_DRG_WT_NUM

LABEL: Claim PPS Capital DRG Weight Number

DESCRIPTION: The number used to determine a transfer adjusted case mix index for capital, under the prospective payment system (PPS). The number is determined by multiplying the Diagnosis Related Group Code (DRG) weight times the discharge fraction.

Medicare assigns a weight to each DRG to reflect the average cost of caring for patients with the DRG compared to the average of all types of Medicare cases. This variable reflects the weight that is applied to the base payment amount.

The DRG weights in this variable reflect adjustments due to patient characteristics and factors related to the stay. For example, payments are reduced for certain short stay transfers or where patients are discharged to post-acute care. Therefore, for a given DRG, the weight in this field may vary.

SHORT NAME: DRGWTAMT

LONG NAME: CLM_PPS_CPTL_DRG_WT_NUM

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/)


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**CLM_PPS_CPTL_DSPRPTNT_SHR_AMT**

**LABEL:**  
Claim PPS Capital Disproportionate Share Amount

**DESCRIPTION:**  
The amount of disproportionate share (rate reflecting indigent population served) portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

**SHORT NAME:**  
DISP_SHR

**LONG NAME:**  
CLM_PPS_CPTL_DSPRPTNT_SHR_AMT

**TYPE:**  
NUM

**LENGTH:**  
12

**SOURCE:**  
NCH

**VALUES:**  
XXX.XX

**COMMENT:**  
Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/)).

Also, in the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference:).
**CLM_PPS_CPTL_EXCPTN_AMT**

**LABEL:** Claim PPS Capital Exception Amount

**DESCRIPTION:** The capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

**SHORT NAME:** CPTL_EXP

**LONG NAME:** CLM_PPS_CPTL_EXCPTN_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/))


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**CLM_PPS_CPTL_FSP_AMT**

**LABEL:** Claim PPS Capital Federal Specific Portion (FSP) Amount

**DESCRIPTION:** The amount of the federal specific portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

**SHORT NAME:** CPTL_FSP

**LONG NAME:** CLM_PPS_CPTL_FSP_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/))

**CLM_PPS_CPTL_IME_AMT**

**LABEL:** Claim PPS Capital Indirect Medical Education (IME) Amount

**DESCRIPTION:** The amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress to augment normal prospective payment system [PPS] payments for teaching hospitals to compensate them for higher patient costs resulting from medical education programs for interns and residents) portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

**SHORT NAME:** IME_AMT

**LONG NAME:** CLM_PPS_CPTL_IME_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/)).

**CLM_PPS_CPTL_OUTLIER_AMT**

**LABEL:** Claim PPS Capital Outlier Amount

**DESCRIPTION:** The amount of the outlier portion of the PPS payment for capital.

This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

**SHORT NAME:** CPTLOUTL

**LONG NAME:** CLM_PPS_CPTL_OUTLIER_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/))

**CLM_PPS_IND_CD**

**LABEL:** Claim PPS Indicator Code

**DESCRIPTION:** The code indicating whether or not:

1. the claim is from the prospective payment system (PPS), and/or
2. the beneficiary is a deemed insured MQGE (Medicare Qualified Government Employee)

**SHORT NAME:** PPS_IND

**LONG NAME:** CLM_PPS_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- Blank = Not a PPS bill
- 2 = PPS bill; claim contains PPS indicator

**COMMENT:** —
**CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT**

**LABEL:** Claim PPS Old Capital Hold Harmless Amount

**DESCRIPTION:** This amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'.

The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.

**SHORT NAME:** HLDHRMLS

**LONG NAME:** CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/)).

**CLM_PRCR_RTRN_CD**

**LABEL:** Claim Pricer Return Code  

**DESCRIPTION:** The code used to identify various prospective payment system (PPS) payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by the PRICER tool.

**SHORT NAME:** CLM_PRCR_RTRN_CD  

**LONG NAME:** CLM_PRCR_RTRN_CD  

**TYPE:** CHAR  

**LENGTH:** 2  

**SOURCE:** NCH  

**VALUES:** The meaning of the values varies by type of bill (TOB)

****Inpatient Hospital Pricer Return Codes*****  

***************TOB 11X***********************

**Inpatient Hospital Payment return codes:**

- **00** = Paid normal DRG payment
- **01** = Paid as a day outlier (NOTE: day outlier no longer being paid as of 10/1/97)
- **02** = Paid as a cost outlier
- **03** = Transfer paid on a per diem basis up to and including the full DRG
- **05** = Transfer paid on a per diem basis up to and including the full DRG which also qualified for a cost outlier payment
- **06** = Provider refused cost outlier
- **10** = DRG is 209, 210, or 211 and post-acute transfer
- **12** = Post-acute transfer with specific DRGs. The following DRG's: 14, 113, 236, 263, 264, 429, 483
- **14** = Paid normal DRG payment with per diem days = or > GM ALOS
- **16** = Paid as a cost outlier with per diem days = or > GM ALOS
- **33** = For inpatient PPS, it means paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric
**Inpatient Hospital Error return codes:**

51 = No provider specific information found

52 = Invalid MSA# in provider file

53 = Waiver state — not calculated by PPS

54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438, 456, 457, 458

55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS

56 = Invalid length of stay

57 = Review code invalid (Not 00, 03, 06, 07, 09)

58 = Total charges not numeric

61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60

62 = Invalid number of covered days

65 = PAY-CODE not = A, B or C on provider specific file for capital

67 = Cost outlier with LOS > covered days

***Inpatient Rehab Facility (IRF) Pricer Return Codes***

**IRF Payment return codes:**

00 = Paid normal CMG payment without outlier

01 = Paid normal CMG payment with outlier

02 = Transfer paid on a per diem basis without outlier

03 = Transfer paid on a per diem basis with outlier

04 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — without outlier

05 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — with outlier

06 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — without outlier

07 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — with outlier

10 = Paid normal CMG payment with penalty without outlier

11 = Paid normal CMG payment with penalty with outlier

12 = Transfer paid on a per diem basis with penalty without outlier

13 = Transfer paid on a per diem basis with penalty with outlier

14 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — with penalty without outlier

15 = Blended CMG payment — 2/3 federal PPS rate + 1/3 provider specific rate — with penalty with outlier

16 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — with penalty without outlier

17 = Blended transfer payment — 2/3 federal PPS transfer rate + 1/3 provider specific rate — with penalty with outlier
IRF Error return codes:

- 50 = Provider specific rate not numeric
- 51 = Provider record terminated
- 52 = Invalid wage index
- 53 = Waiver state — not calculated by PPS
- 54 = CMG on claim not found in table
- 55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS
- 56 = Invalid length of stay
- 57 = Provider specific rate zero when blended payment requested
- 58 = Total covered charges not numeric
- 59 = Provider specific record not found
- 60 = MSA wage index record not found
- 61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60
- 62 = Invalid number of covered days
- 65 = Operating cost-to-charge ratio not numeric
- 67 = Cost outlier with LOS > covered days or cost outlier threshold calculation
- 72 = Invalid blend indicator (not 3 or 4)
- 73 = Discharged before provider FY begin date
- 74 = Provider FY begin date not in 2002

***Long-Term Care Hospital (LTCH) Pricer Return Codes***

LTCH Payment return codes:

- 00 = Normal DRG payment without outlier
- 01 = Normal DRG payment with outlier
- 02 = Short stay payment without outlier
- 03 = Short stay payment with outlier
- 04 = Blend year 1 — 80% facility rate plus 20% normal DRG payment without outlier
- 05 = Blend year 1 — 80% facility rate plus 20% normal DRG payment with outlier
- 06 = Blend year 1 — 80% facility rate plus 20% short stay payment without outlier
- 07 = Blend year 1 — 80% facility rate plus 20% short stay payment with outlier
- 08 = Blend year 2 — 60% facility rate plus 40% normal DRG payment without outlier
- 09 = Blend year 2 — 60% facility rate plus 40% normal DRG payment with outlier
- 10 = Blend year 2 — 60% facility rate plus 40% short stay payment without outlier
- 11 = Blend year 2 — 60% facility rate plus 40% short stay payment with outlier
- 12 = Blend year 3 — 40% facility rate plus 60% normal DRG payment without outlier
- 13 = Blend year 3 — 40% facility rate plus 60% normal DRG payment with outlier
- 14 = Blend year 3 — 40% facility rate plus 60% short stay payment without outlier
15 = Blend year 3 — 40% facility rate plus 60% short stay payment with outlier
16 = Blend year 4 — 20% facility rate plus 80% normal DRG payment without outlier
17 = Blend year 4 — 20% facility rate plus 80% normal DRG payment with outlier
18 = Blend year 4 — 20% facility rate plus 80% short stay payment without outlier
19 = Blend year 4 — 20% facility rate plus 80% short stay payment with outlier
20 = Short stay payment based on estimated cost without outlier
21 = Short stay payment based on LTC-DRG per diem without outlier
22 = For long-term care PPS, it means short stay payment based on blend of LTC-DRG PER DIEM and IPPS comparable amount without outlier
23 = Short stay payment based on estimated cost with outlier
24 = Short stay payment based on LTC-DRG per diem without outlier
25 = Short stay payment based on blend of LTC-DRG per diem and IPPS comp amt with outlier
26 = For long-term care PPS, it means short stay payment based on IPPS-comparable threshold without outlier
27 = Short stay payment based on IPPS comparable threshold with outlier
28 = Subclause (II) without outlier
29 = Subclause (II) with outlier

**LTCH Error return codes:**

50 = Provider specific rate not numeric
51 = Provider record terminated
52 = Invalid wage index
53 = Waiver state — not calculated by PPS
54 = DRG on claim not found in table
55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS
56 = Invalid length of stay
57 = Provider specific rate zero when blended payment requested
58 = Total covered charges not numeric
59 = Provider specific record not found
60 = MSA wage index record not found
61 = Lifetime reserve days not numeric or lifetime reserve days greater than 60
62 = Invalid number of covered days or covered days < life time reserve days
65 = Operating cost-to-charge ratio not numeric
67 = Cost outlier with length of stay > covered days
68 = Provider specific state code invalid
72 = Invalid blend indicator (not 1 thru 5)
73 = Discharged before provider FY begin date
74 = Provider FY begin date not in 2002
A0 = Blend yr, site-neutral based on cost, psych/rehab
A1 = Blend yr, site-neutral based on cost, outlier, psych/rehab
A2 = Blend yr, site-neutral based on cost, SSO, psych/rehab
A3 = Blend yr, site-neutral based on cost, SSO, outlier, psych/rehab
A4 = Blend yr, site-neutral based on IPPS, psych/rehab
A5 = Blend yr, site-neutral based on IPPS, outlier, psych/rehab
A6 = Blend yr, site-neutral based on IPPS, SSO, psych/rehab
A7 = Blend yr, site-neutral based on IPPS, SSO, outlier, psych/rehab
AA = Site-neutral based on cost, psych/rehab
AB = Site-neutral based on IPPS, psych/rehab
AC = Site-neutral based on IPPS, outlier, psych/rehab
B0 = Blend yr, site-neutral based on cost, vent
B1 = Blend yr, site-neutral based on cost, outlier, vent
B2 = Blend yr, site-neutral based on cost, SSO, vent
B3 = Blend yr, site-neutral based on cost, SSO, outlier, vent
B4 = Blend yr, site-neutral based on IPPS, vent
B5 = Blend yr, site-neutral based on IPPS, outlier, vent
B6 = Blend yr, site-neutral based on IPPS, SSO, vent
B7 = Blend yr, site-neutral based on IPPS, SSO, outlier, vent
BA = Site-neutral based on cost, vent
BB = Site-neutral based on IPPS, vent
BC = Site-neutral based on IPPS, outlier, vent
BD = SSO standard payment, vent
BE = SSO standard payment, outlier, vent
BF = Standard payment full DRG, vent
BG = Standard payment full DRG, outlier, vent
C0 = Blend yr, site-neutral based on cost, no vent
C1 = Blend yr, site-neutral based on cost, outlier, no vent
C2 = Blend yr, site-neutral based on cost, SSO, no vent
C3 = Blend yr, site-neutral based on cost, SSO, outlier, no vent
C4 = Blend yr, site-neutral based on IPPS, no vent
C5 = Blend yr, site-neutral based on IPPS, outlier, no vent
C6 = Blend yr, site-neutral based on IPPS, SSO, no vent
C7 = Blend yr, site-neutral based on IPPS, SSO, outlier, no vent
CA = Site-neutral based on cost, no vent
CB = Site-neutral based on IPPS, no vent
CC = Site-neutral based on IPPS, outlier, no vent
CD = SSO standard payment, no vent
CE = SSO standard payment, outlier, no vent
CF = Standard payment full DRG, no vent
CG = Standard payment full DRG, outlier, no vent

*************SNF Pricer Return Codes**********

***************TOB 21X**********************

SNF payment return codes:
00 = RUG III group rate returned

SNF Error return codes:
20 = Bad RUG code
30 = Bad MSA code
40 = Thru date < July 1, 1998 or invalid
50 = Invalid federal blend for that year
60 = Invalid federal blend
61 = Federal blend = 0 and SNF thru date < January 1, 2000

**********Hospice Pricer Return Codes**********

***************TOB 81X or 82X***********************

Hospice payment return codes:
00 = Home rate returned

Hospice Error return codes:
10 = Bad units
20 = Bad units 2 < 8
30 = Bad MSA code
40 = Bad hospice wage index from MSA file
50 = Bad bene wage index from MSA file
51 = Bad provider number
****** Home Health Pricer Return Codes ******

***** TOB 32X or 33X, DOS 10/1/2000 and after *****

Home health payment return codes:

00 = Final payment where no outlier applies
01 = Final payment where outlier applies
03 = Initial percentage payment, 0%
04 = Initial percentage payment, 50%
05 = Initial percentage payment, 60%
06 = LUPA payment only
07 = Final payment, SCIC
08 = Final payment, SCIC with outlier
09 = Final payment, PEP
11 = Final payment, PEP with outlier
12 = Final payment, SCIC within PEP
13 = Final payment, SCIS within PEP with outlier

Home health error return codes:

10 = Invalid TOB
15 = Invalid PEP days
16 = Invalid HRG days, > 60
20 = PEP indicator invalid
25 = Med review indicator invalid
30 = Invalid MSA code
35 = Invalid initial payment indicator
40 = Dates < October 1, 2000 or invalid
70 = Invalid HRG code
75 = No HRG present in 1st occurrence
80 = Invalid revenue code
85 = No revenue code present on HH final claim/adjustment

****** Outpatient PPS Pricer Return Codes ******

Outpatient PPS payment return codes:

01 = Line processed to payment
20 = Line processed but payment = 0 bene deductible = > adjusted payment
22 = For outpatient PPS, it means daily coinsurance limitation

Outpatient PPS error return codes:

30 = Missing, deleted, or invalid APC
38 = Missing or invalid discount factor
40 = Invalid service indicator passed by the OCE
41 = Service indicator invalid for OPPS PRICER
42 = APC = '00000' or (packaging flag = 1 or 2)
43 = Payment indicator not = to 1 or 5 thru 9
44 = Service indicator = 'H' but payment indicator not = to 6
45 = Packaging flag not = to 0
46 = Line-item denial/reject flag not = to 0 or line-item denial/reject flag = to 1 and (APC not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325 or 0373 or 0374)) or line-item action flag not = to 1
47 = Line-item action flag = 2 or 3
48 = Payment adjustment flag not valid
49 = Site of service flag not = to 0 or (APC 0033 is not on the claim and service indicator = 'P' or APC = 0322, 0325, 0373, 0374)
50 = Wage index not located
51 = Wage index equals zero
52 = Provider specific file wage index reclassification code invalid or missing
53 = Service from date not numeric or < 20000801
54 = Service from date < provider effective date or service from date > provider termination date

***End-stage Renal Disease (ESRD) Pricer Return Codes***

ESRD payment return codes:
00 = ESRD PPS payment calculated
01 = ESRD facility rate > zero

ESRD error return codes:
22 = For ESRD Pricer, it means PPS w/acute comorbid, training
26 = For ESRD Pricer, it means PPS w/chronic comorbid, low volume, training
31 = ESRD Pricer means PPS w/low BMI
32 = ESRD Pricer means PPS w/low volume, onset
33 = For ESRD Pricer, it means PPS w/outlier, training
50 = ESRD facility rate not numeric
52 = Provider type not = '40' or '41'
53 = Special payment indicator not = '1' or blank
54 = Date of birth not numeric or = zero
55 = Patient weight not numeric or = zero
56 = Patient height not numeric or = zero
57 = Revenue center code not in range
58 = Condition code not = '73' or '74' or blank
60 = MSA wage adjusted rate record not found
98 = Claim through date before 4/1/2005 or not numeric

COMMENT: The payment return code identifies the type of payment calculated by the PRICER software.
CLM_PRCR_VRSN_CD

LABEL: Claim Pricer Version Code

DESCRIPTION: This field indicates the prospective payment system (PPS) Pricer version used to process payment for the claim.

SHORT NAME: CLM_PRCR_VRSN_CD

LONG NAME: CLM_PRCR_VRSN_CD

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: These are examples of observed values; this is not a comprehensive list.
2022.1
C2022.1
SNFPR22.1

COMMENT: This field is not populated prior to 2021.
### CLM_RLT_COND_CD

**LABEL:** Claim Related Condition Code

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

**SHORT NAME:** RLT_COND

**LONG NAME:** CLM_RLT_COND_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>01</td>
<td>Insurance related — medical condition incurred during military service</td>
</tr>
<tr>
<td>02</td>
<td>Employment related — patient alleged that the medical condition causing this episode of care was due to environment/events resulting from employment</td>
</tr>
<tr>
<td>03</td>
<td>Patient covered by insurance not reflected here — indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill</td>
</tr>
<tr>
<td>04</td>
<td>Health Maintenance Organization (HMO) enrollee — Medicare beneficiary is enrolled in an HMO. Hospital must also expect to receive payment from HMO</td>
</tr>
<tr>
<td>05</td>
<td>Lien has been filed — provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient</td>
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<td>06</td>
<td>ESRD patient in the first 30 months of entitlement covered by employer group health insurance</td>
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</table>
07 = Treatment of nonterminal condition for hospice patient — the patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement

08 = Beneficiary would not provide information concerning other insurance coverage

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

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

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

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

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

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

15 = Payer code — Clean claim. Delayed in CMS’s processing system

16 = Payer code — SNF transition exemption — an exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days before the admission date

17 = Patient is homeless

18 = Maiden name retained — a dependent spouse entitled to benefits who does not use her husband’s last name

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

20 = Beneficiary requested billing — provider realizes the services on this bill are at a non-covered level of care or otherwise excluded from coverage, but the bene has requested formal determination

21 = Billing for denial notice — the SNF or HHA realizes services are at a non-covered level of care or excluded but requests a Medicare denial in order to bill Medicaid or other insurer

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

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

24 = Home IV patient also receiving HHA services — the patient is under care of HHA while receiving home IV drug therapy services
25 = Reserved for national assignment

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

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

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

29 = Disabled beneficiary and/or family member’s LGHP is secondary to Medicare — qualifying LGHP for employer having fewer than 100 full and part-time employee

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

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

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

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

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

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

37 = Ward accommodation at patient’s request — patient is assigned to ward accommodations at patient’s request

38 = Semi-private room not available — indicates that either private or ward accommodations were assigned because semi-private accommodations were not available

39 = Private room medically necessary — patient needed a private room for medical reasons

40 = Same day transfer — patient transferred to another facility before midnight of the day of admission

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

42 = Continuing Care Not Related to inpatient Admission — continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services. (eff. 10/2001)

43 = Continuing Care Not Provided Within Prescribed Post-Discharge Window — continuing care was related to the inpatient admission, but the prescribed care was not provided within the post-discharge window. (eff. 10/2001)

44 = Inpatient Admission Changed to Outpatient — for use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. (eff. 4/1/2004)
45 = Reserved for national assignment

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

47 = Reserved for TRICARE

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

49 = Product Replacement within Product Lifecycle — replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)

50 = Product Replacement for Known Recall of a Product — manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006)

51 = Attestation of unrelated outpatient nondiagnostic services (eff. 4/1/11)

52 = Reserved for national assignment

53 = Initial placement of a medical device provided as part of a clinical trial or a free sample (eff. 7/1/15)

54 = No skilled HH visits in billing period (eff. 7/2016)

55 = SNF bed not available — the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available

56 = Medical appropriateness — patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period

57 = SNF readmission — patient previously received Medicare covered SNF care within 30 days of the current SNF admission

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

59 = Non-primary ESRD Facility — ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. (eff. 10/2004)

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

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

62 = Payer code — PIP bill — this bill is a periodic interim payment bill

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

64 = Payer code — other than clean claim — the claim is not a 'clean claim'

65 = Payer code — non-PPS bill — the bill is not a prospective payment system bill
66 = Hospital Does Not Wish Cost Outlier Payment — bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)

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

68 = Beneficiary elects to use LTR days

69 = IME/DGME/NandA Payment Only — providers request for request for a supplemental payment for IME/DGME/NandAH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health)

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

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

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

73 = Self-care training — billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis

74 = Home — billing is for a patient who received dialysis services at home

75 = Home dialysis patient using a dialysis machine that was purchased under the 100% program

76 = Back-up in facility dialysis — billing is for a patient who received dialysis services in a back-up facility

77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by the primary payer as payment in full — no Medicare payment is due

78 = New coverage not implemented by HMO, indicates newly covered service under Medicare for which HMO does not pay

79 = CORF services provided off site — code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site

80 = Home Dialysis — nursing facility — home dialysis furnished in a SNF or nursing facility (eff. 4/2005)

81 = C-sections/inductions < 39 weeks - medical necessity (eff. 10/1/13)

82 = C-sections/inductions < 39 weeks - elective (eff. 10/1/13)

83 = C-sections/inductions 39 weeks or greater (eff. 10/1/13)

84 = Dialysis for acute kidney injury (AKI) (eff. 1/1/17)

85 = Delayed Recertification of hospice Terminal Illness (eff. 1/2017)

86 = Additional hemodialysis treatments with medical justification (eff. date TBD)

87 = ESRD self-care retraining (eff. 7/1/17)

88 = Allogeneic stem cell transplant related donor charges (eff. 7/1/20)
89 = Opioid Treatment Program (OTP) — indicates claim is for opioid treatment services (eff. 1/2021)

90 = Service provided as part of an Expanded Access Approval (EA) to the IPPS Price. Code is for inpatient and Outpatient claims that have reported EA services (eff. 7/2021)

91 = Service provided as part of an Emergency Use Authorization (EUA) to the IPPS Pricer. Code is for inpatient and Outpatient claims that have reported Emergency EUA services (eff. 7/2021)

92–97 = Reserved for state assignment

98 = Payer code - Data Associated with DRG 468 Has Been Validated (eff. 7/2023)

A0 = TRICARE External Partnership Program. This code identifies TRICARE claims submitted under the External Partnership Program. (previously this was a Special Zip Code Reporting — five-digit zip code of the location from which the beneficiary is initially placed on board the ambulance; eff. 9/2001); obsolete

A1 = EPSDT/CHAP — early and periodic screening diagnosis and treatment special program indicator code

A2 = Physically handicapped children’s program — services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped

A3 = Special federal funding — designed for uniform use by state uniform billing committees. Special program indicator code

A4 = Family planning — designed for uniform use by state uniform billing committees. Special program indicator code

A5 = Disability — designed for uniform use by state uniform billing committees

A6 = PPV/Medicare — identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision

A7 = Induced abortion to avoid danger to woman’s life

A8 = Induced abortion — victim of rape/incest. Special program indicator code

A9 = Second opinion surgery — services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply

AA = Abortion performed due to rape (eff. 10/1/2002)

AB = Abortion performed due to incest (eff. 10/1/2002)

AC = Abortion performed due to serious fetal genetic defect, deformity, or abnormality (eff. 10/1/2002)

AD = Abortion performed due to a life endangering physical condition caused by, arising from, or exacerbated by the pregnancy itself (eff. 10/1/2002)

AE = Abortion performed due to physical health of mother that is not life endangering (eff. 10/1/2002)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AF</td>
<td>Abortion performed due to emotional/psychological health of mother (eff. 10/1/2002)</td>
</tr>
<tr>
<td>AG</td>
<td>Abortion performed due to social economic reasons (eff. 10/1/2002)</td>
</tr>
<tr>
<td>AH</td>
<td>Elective abortion (eff. 10/1/2002)</td>
</tr>
<tr>
<td>AI</td>
<td>Sterilization (eff. 10/1/2002)</td>
</tr>
<tr>
<td>AJ</td>
<td>Payer responsible for copayment (4/1/2003)</td>
</tr>
<tr>
<td>AK</td>
<td>Air ambulance required — for ambulance claims. Time needed to transport poses a threat. (eff. 10/16/2003)</td>
</tr>
<tr>
<td>AL</td>
<td>Specialized treatment/bed unavailable — for ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility. (eff. 10/16/2003)</td>
</tr>
<tr>
<td>AM</td>
<td>Non-emergency medically necessary stretcher transport required — for ambulance claims. Non-emergency medically necessary stretcher transport required. (eff. 10/16/2003)</td>
</tr>
<tr>
<td>AN</td>
<td>Preadmission screening not required — person meets the criteria for an exemption from preadmission screening. (eff. 1/1/2004)</td>
</tr>
<tr>
<td>B0</td>
<td>Medicare Coordinated Care Demonstration Program — patient is a participant in a Medicare Coordinated Care Demonstration (eff. 10/2001)</td>
</tr>
<tr>
<td>B1</td>
<td>Beneficiary ineligible for demonstration program (eff. 1/2002)</td>
</tr>
<tr>
<td>B2</td>
<td>Critical Access hospital Ambulance Attestation — attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule</td>
</tr>
<tr>
<td>B3</td>
<td>Pregnancy indicator — indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/2003)</td>
</tr>
<tr>
<td>B4</td>
<td>Admission unrelated to discharge — admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004</td>
</tr>
<tr>
<td>B5</td>
<td>Special program indicator reserved for national assignment</td>
</tr>
<tr>
<td>B6</td>
<td>Special program indicator reserved for national assignment</td>
</tr>
<tr>
<td>B7</td>
<td>Special program indicator reserved for national assignment</td>
</tr>
<tr>
<td>B8</td>
<td>Special program indicator reserved for national assignment</td>
</tr>
<tr>
<td>B9</td>
<td>Special program indicator reserved for national assignment</td>
</tr>
<tr>
<td>C0</td>
<td>Reserved for national assignment</td>
</tr>
<tr>
<td>C1</td>
<td>Approved as billed — claim has been reviewed by the QIO and has been fully approved including any outlier</td>
</tr>
<tr>
<td>C2</td>
<td>QIO approval indicator services. <strong>NOTE:</strong> Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X)</td>
</tr>
<tr>
<td>C3</td>
<td>Partial approval — some portion (days or services). From/Through dates of the approved portion of the stay are shown as code “M0” in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code “77” in FL 36 or code “46” in FL 39–41)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>C4</td>
<td>Admission denied — the patient’s need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary</td>
</tr>
<tr>
<td>C5</td>
<td>Post-payment review applicable — any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed</td>
</tr>
<tr>
<td>C6</td>
<td>Preadmission/Pre-procedure authorization — the QIO authorized this admission/procedure but has not reviewed the services provided</td>
</tr>
<tr>
<td>C7</td>
<td>Extended authorization — the QIO has authorized these services for an extended length of time but has not reviewed the services provided</td>
</tr>
<tr>
<td>C8</td>
<td>Reserved for national assignment. QIO approval indicator services</td>
</tr>
<tr>
<td>C9</td>
<td>Reserved for national assignment. QIO approval indicator services</td>
</tr>
<tr>
<td>D0</td>
<td>Changes to service dates</td>
</tr>
<tr>
<td>D1</td>
<td>Changes in charges</td>
</tr>
<tr>
<td>D2</td>
<td>Changes in revenue codes/HCPCS/HIPPS rate code — report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)</td>
</tr>
<tr>
<td>D3</td>
<td>Second or subsequent interim PPS bill</td>
</tr>
<tr>
<td>D4</td>
<td>Change in ICD-9-CM diagnosis and/or procedure code</td>
</tr>
<tr>
<td>D5</td>
<td>Cancel only to correct a beneficiary claim account number (HICN) or provider identification number</td>
</tr>
<tr>
<td>D6</td>
<td>Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill)</td>
</tr>
<tr>
<td>D7</td>
<td>Change to make Medicare the secondary payer</td>
</tr>
<tr>
<td>D8</td>
<td>Change to make Medicare the primary payer</td>
</tr>
<tr>
<td>D9</td>
<td>Any other change</td>
</tr>
<tr>
<td>DR</td>
<td>Disaster relief (eff. 10/2005) — code used to facilitate claims processing and track services/items provided to victims of disasters</td>
</tr>
<tr>
<td>E0</td>
<td>Change in patient status</td>
</tr>
<tr>
<td>EY</td>
<td>Payer code — National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study</td>
</tr>
<tr>
<td>G0</td>
<td>Distinct medical visit — report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits</td>
</tr>
<tr>
<td>H0</td>
<td>Delayed filing, statement of intent submitted — statement of intent was submitted within the qualifying period to specifically identify the existence of another third-party liability situation</td>
</tr>
<tr>
<td>H3</td>
<td>Reoccurrence of GI bleed comorbid category (eff. 1/1/11)</td>
</tr>
<tr>
<td>H4</td>
<td>Reoccurrence of pneumonia category (eff. 1/1/11)</td>
</tr>
</tbody>
</table>
H5 = Reoccurrence of pericarditis comorbid category (eff. 1/1/11)

M0 = Payer only — all-inclusive rate for outpatient services. Used by a critical access hospital electing to be paid an all-inclusive rate for outpatient services. Obsolete

M1 = Payer code — roster billed influenza virus vaccine or pneumococcal pneumonia vaccine (PPV). Obsolete

M2 = Payer code — HHA Payment Significantly Exceeds Total Charges — used when payment to an HHA is significantly more than covered billed charges. Obsolete

M3 = Payer code — SNF three day stay bypass for NG/Pioneer ACO waiver (eff. 7/2023)

M4 = Payer code — presence of infected wound or wound with morbid obesity (eff. 7/2023)

M5 = Payer code — not currently used by Medicare (eff. 7/2023)

M6 = Payer code — Pennsylvania (PA) Rural Health Model (PARHM)

M7 = Payer only — shared system Medicare deductible bypass (eff. 7/2023)

M8 = Payer only — shared system Medicare coinsurance bypass (eff. 7/2023)

M9 = Payer only — shared system Medicare deductible/coinsurance bypass (eff. 7/2023)

MA = Payer code — GI bleed. (Bill Type 072x), Managed Care Enrollee (Bill Type 012x, 013x, and 076x)

MB = Payer code — Pneumonia. (Bill Type 072x)

MC = Payer code — Pericarditis. (Bill Type 072x)

MD = Payer code — Myelodysplastic Syndrome. (Bill Type 072x)

ME = Payer code — Hereditary hemolytic and sickle cell anemia. (Bill Type 072x)

MF = Payer code — monoclonal gammopathy. (Bill Type 072x)

MG = Payer code — Grandfathered Tribal Federally Qualified Health Centers

MH = Payer only — MAC Medicare deductible bypass (eff. 7/2023); Acute hospital care at home (payer only code) eff. 7/2021

MI = Payer only — MAC Medicare coinsurance bypass (eff. 7/2023)

MJ = Payer only — MAC Medicare deductible/coinsurance bypass (eff. 7/2023)

MO = Payer code — MAC override appeal timeliness.

MP = Payer code — PHP claim contains initial admit week

MQ = Payer code — PHP claim contains final discharge week

MS = Payer only — Medicare SNF three-day edit bypass (eff. 7/2023)

MV = Payer code — 20 hours for partial PHP subsequent week not met

MW = Payer code — 20 hours for partial PHP initial week net met
MX = Payer code — wrong surgery on patient (inpatient)

MY = Payer code — surgery wrong body part (inpatient), outlier cap bypass (CMHC)

MZ = Payer code — surgery wrong patient (inpatient), IOCE error code bypass (outpatient)

R1 = Request for reopening reason code — mathematical or computational mistakes (eff. 1/1/16)

R2 = Request for reopening reason code — inaccurate data entry (eff. 1/1/16)

R3 = Request for reopening reason code — misapplication of a fee schedule (eff. 1/1/16)

R4 = Request for reopening reason code — computer errors (eff. 1/1/16)

R5 = Request for reopening reason code — incorrectly identified duplicate claim (eff. 1/1/16)

R6 = Request for reopening reason code — other clerical errors or minor errors and omissions not specified in R1-R5 above (eff. 1/1/16)

R7 = Request for reopening reason code — corrections other than clerical errors (eff. 1/1/16)

R8 = Request for reopening reason code — new and material evidence (eff. 1/1/16)

R9 = Request for reopening reason code — faulty evidence (eff. 1/1/16)

UU = Payer code — not currently used by Medicare

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

XX = Transgender/Hermaphrodite beneficiaries (eff. 1/2/2007)

ZA = Payer code — inpatient. Positive test result is not included in the patient's medical record. eff. 7/2021

ZB = Payer code — inpatient. Service provided as part of an expanded access approval. eff. 7/2021

ZC = Payer code — inpatient. Clinical trial of a different product.

ZD–ZZ = Reserved. Payer code — not currently in use by Medicare

COMMENT: —
**CLM_RLT_OCRNC_CD**

**LABEL:** Claim Related Occurrence Code

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

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

**SHORT NAME:** OCRNC_CD

**LONG NAME:** CLM_RLT_OCRNC_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

01 THRU 09 = Accident

10 THRU 19 = Medical condition

20 THRU 39 = Insurance related

40 THRU 69 = Service related

A1–A3= Miscellaneous

01 = Auto accident — the date of an auto accident

02 = No-fault insurance involved, including auto accident/other — the date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt)

03 = Accident/tort liability — the date of an accident resulting from a third party’s action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability

04 = Accident/employment related — the date of an accident relating to the patient’s employment

05 = Other accident — the date of an accident not described by the codes 01 thru 04

06 = Crime victim — code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties

07 = Reserved for national assignment

08 = Reserved for national assignment

11 = Onset of symptoms/illness — the date the patient first became aware of symptoms/illness

12 = Date of onset for a chronically dependent individual — code indicates the date the patient/bene became a chronically dependent individual

13 = Reserved for national assignment
14 = Reserved for national assignment

15 = Reserved for national assignment

16 = Reserved for national assignment

17 = Date outpatient occupational therapy plan established or last reviewed — code indicating the date an occupational therapy plan was established or last reviewed

18 = Date of retirement (patient/bene) — code indicates the date of retirement for the patient/bene

19 = Date of retirement spouse — code indicates the date of retirement for the patient's spouse

20 = Guarantee of payment began — the date on which the provider began claiming Medicare payment under the guarantee of payment provision

21 = UR notice received — code indicating the date of receipt by the hospital and SNF of the UR committee's finding that the admission or future stay was not medically necessary

22 = Active care ended — the date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used

23 = Payer only — date of cancellation of hospice benefits — the date the RHHI cancelled the hospice benefit. (eff. 10/2000). NOTE: This will be different than the revocation of the hospice benefit by beneficiaries

24 = Date insurance denied — the date the insurer's denial of coverage was received by a higher priority payer

25 = Date benefits terminated by primary payer — the date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient

26 = Date skilled nursing facility (SNF) bed available — the date on which a SNF bed became available to a hospital inpatient who required only SNF level of care

27 = Date of hospice certification or re-certification — code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/2001)

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

28 = Date comprehensive outpatient rehabilitation plan established or last reviewed — code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed. Not used by hospital unless owner of facility
29 = Date OPT plan established or last reviewed — the date a plan of treatment was established for outpatient physical therapy. Not used by hospital unless owner of facility

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

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

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

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

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

35 = Date treatment started for physical therapy — code indicates the date services were initiated by the billing provider for physical therapy

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

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

38 = Date treatment started for home IV therapy — date the patient was first treated in his home for IV therapy

39 = Date discharged on a continuous course of IV therapy — date the patient was discharged from the hospital on a continuous course of IV therapy

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

41 = Date of first test for pre-admission testing — the date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/2001)

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

43 = Scheduled date of canceled surgery — date which ambulatory surgery was scheduled. (eff. 9/2001)
44 = Date treatment started for occupational therapy — code indicates the date services were initiated by the billing provider for occupational therapy

45 = Date treatment started for speech therapy — code indicates the date services were initiated by the billing provider for speech therapy

46 = Date treatment started for cardiac rehabilitation — code indicates the date services were initiated by the billing provider for cardiac rehabilitation

47 = Date cost outlier status begins — code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/2001)

48 = Payer only — not currently used by Medicare

49 = Payer only — original Notice of Election (NOE) receipt date

50–55 = Reserved for state assignment

56 = Hospice — incorrect date of hospice notification of election (NOE). This code indicates the date of certification or recertification of the hospice benefit period, which has been corrected (the corrected date appears in the record for occurrence code = 26). (eff. 1/2018)

57–60 = Reserved for state assignment

61 = Hospital discharge date (HHA only) (eff. 1/1/20)

62 = Other institutional discharge date (HHA only) (eff. 1/1/20)

A1 = Birthdate, insured A — the birthdate of the individual in whose name the insurance is carried

A2 = Effective date, insured A policy — code indicating the first date insurance is in force

A3 = Benefits exhausted — code indicating the last date for which benefits are available and after which no payment can be made to payer A

A4 = Split Bill Date — date patient became eligible due to medically needy spend down (sometimes referred to as "Split Bill Date")

B1 = Birthdate, insured B — the birthdate of the individual in whose name the insurance is carried

B2 = Effective date, insured B policy — code indicating the first date insurance is in force

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

C1 = Birthdate, insured C — the birthdate of the individual in whose name the insurance is carried

C2 = Effective date, insured C policy — a code indicating the first date insurance is in force
C3 = Benefits exhausted — code indicating the last date for which benefits are available and after which no payment can be made to payer C.

COMMENT: —
**CLM_RLT_OCRNC_DT**

**LABEL:** Claim Related Occurrence Date

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

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

**SHORT NAME:** OCRNCDT

**LONG NAME:** CLM_RLT_OCRNC_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
CLM_RP_IND_CD

LABEL: Claim Representative Payee (RP) Indicator Code

DESCRIPTION: Claim Representative Payee (RP) Indicator Code

SHORT NAME: CLM_RP_IND_CD

LONG NAME: CLM_RP_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: R = bypass representative payee
Null/missing = not applicable

COMMENT: This field is used to designate by-passing of the prior authorization processing for claims with a representative payee when an 'R' is present in the field.

This field was added in April 2018.
**CLM_RSDL_PYMT_IND_CD**

**LABEL:** Claim Residual Payment Indicator Code

**DESCRIPTION:** Claim Residual Payment Indicator Code

**SHORT NAME:** CLM_RSDL_PYMT_IND_CD

**LONG NAME:** CLM_RSDL_PYMT_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- X = Residual payment
- Null/missing = not applicable

**COMMENT:** This field is used by CWF claims processing for the purpose of bypassing its normal MSP editing that would otherwise apply for ongoing responsibility for medicals (ORM) or worker’s compensation Medicare Set-Aside Arrangements (WCMSA). Normally, CWF does not allow a secondary payment on MSP involving ORM or WCMSA, so the residual payment indicator will be used to allow CWF to make an exception to its normal routine.

This field appears in the data starting 04/2018.
**CLM_SITE_NTRL_PYMT_CST_AMT**

**LABEL:** Claim Site Neutral Payment Based on Cost Amount

**DESCRIPTION:** Under the long-term care hospital (LTCH) prospective payment system (PPS), the payment amount based on estimated cost of the case.

**SHORT NAME:** CLM_SITE_NTRL_PYMT_CST_AMT

**LONG NAME:** CLM_SITE_NTRL_PYMT_CST_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Applies only to inpatient (LTCH) claims. This field is new in October 2015.

For an LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the four fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.
**CLM_SITE_NTRL_PYMT_IPPS_AMT**

**LABEL:** Claim Site Neutral Payment Based on Inpatient Prospective Payment System (IPPS) Amounts

**DESCRIPTION:** Under the long-term care hospital (LTCH) prospective payment system (PPS), the payment amount based on the inpatient prospective payment system (IPPS) comparable amount. This amount does not include any applicable outlier payment amount.

**SHORT NAME:** CLM_SITE_NTRL_PYMT_IPPS_AMT

**LONG NAME:** CLM_SITE_NTRL_PYMT_IPPS_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Applies only to inpatient (LTCH) claims. This field is new in October 2015. For a LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.
**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:** SPAN_CD

**LONG NAME:** CLM_SPAN_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>Payer use only, the non-utilization from/thru dates for PPS-inlier stay where bene had exhausted all full/coinsurance days but covered on cost report. SNF qualifying hospital stay from/thru dates</td>
</tr>
<tr>
<td>71</td>
<td>Hospital prior stay dates — the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission</td>
</tr>
<tr>
<td>72</td>
<td>First/Last visit — the dates of the first and last visits occurring in this billing period if the dates are different from those in the statement covers period</td>
</tr>
<tr>
<td>73</td>
<td>Benefit eligibility period — the inclusive dates during which CHAMPUS medical benefits are available to a sponsor's bene as shown on the bene's ID card</td>
</tr>
<tr>
<td>74</td>
<td>Non-covered level of care — the from/thru dates of a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span code 76, 77, or 79</td>
</tr>
<tr>
<td>75</td>
<td>The from/thru dates of SNF level of care during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. Not applicable to swing bed cases. PPS hospitals use in day outlier cases only</td>
</tr>
<tr>
<td>76</td>
<td>Patient liability — from/thru dates of period of non-covered care for which hospital may charge bene. The FI or PRO must have approved such charges in advance. Patient must be notified in writing three days prior to non-covered period</td>
</tr>
<tr>
<td>77</td>
<td>Provider liability (utilization charged) — the from/thru dates of period of non-covered care for which the provider is liable. Applies to provider liability where bene is charged with utilization and is liable for deductible/coinsurance</td>
</tr>
<tr>
<td>78</td>
<td>SNF prior stay dates — the from/thru dates of any SNF stay that ended within 60 days of this hospital or SNF admission</td>
</tr>
</tbody>
</table>
79 = Payer code — verified non-covered stay dates for which the provider is liable

80 = Prior Same-SNF Stay Dates for Payment Ban Purposes — the from/thru dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital

81 = Antepartum Days (eff. 7/2/12)

82 = Hospital at Home Care Dates — the from/through dates of a period of hospital at home care provided during an inpatient hospital stay. (eff. 7/2022)

83–99 = Reserved for national assignment

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

M1 = Provider liability no utilization — from/thru dates of a period of non-covered care that is denied due to lack of medical necessity or custodial care for which the provider is liable. (eff. 10/2001)

M2 = Dates of inpatient respite care — from/thru dates of a period of inpatient respite care for hospice patients. (eff. 10/2000)

M3 = ICF Level of Care — the from/through dates of a period of intermediate level of care during an inpatient hospital stay

M4 = Residential Level of Care — the from/through dates of a period of residential level of care during an inpatient hospital stay

MR = Reserved for disaster related occurrence span code

Z0-Z9 = Payer code — not currently used by Medicare

ZA-ZZ = Payer code — not currently used by Medicare

COMMENT: —
**CLM_SPAN_FROM_DT**

**LABEL:** Claim Occurrence Span From Date

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

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

**SHORT NAME:** SPANFROM

**LONG NAME:** CLM_SPAN_FROM_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**CLM_SPAN_THRU_DT**

**LABEL:** Claim Occurrence Span Through Date

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

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

**SHORT NAME:** SPANTHRU

**LONG NAME:** CLM_SPAN_THRU_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**CLM_SRC_IP_ADMSN_CD**

**LABEL:** Claim Source Inpatient Admission Code

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

**SHORT NAME:** SRC_ADMS

**LONG NAME:** CLM_SRC_IP_ADMSN_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** For inpatient/SNF claims:

- **0** = ANOMALY: invalid value, if present, translate to '9'
- **1** = Non-Health Care Facility Point of Origin (Physician Referral) — the patient was admitted to this facility upon an order of a physician
- **2** = Clinic referral — the patient was admitted upon the recommendation of this facility's clinic physician
- **3** = HMO referral — reserved for national Prior to 3/08, HMO referral — the patient was admitted upon the recommendation of a health maintenance organization (HMO) physician
- **4** = Transfer from hospital (Different Facility) — the patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient
- **5** = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) — the patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident
- **6** = Transfer from another health care facility — the patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient
- **7** = Emergency room — the patient was admitted to this facility after receiving services in this facility's emergency room department (CMS discontinued this code 07/2010, although a small number of claims with this code appear after that time)
- **8** = Court/law enforcement — the patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative
- **9** = Information not available — how the patient was admitted is not known
- **A** = Reserved for national assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a critical access hospital — patient was admitted/referred to this facility as a transfer from a critical access hospital
B = Transfer from another home health agency — the patient was admitted to this home health agency as a transfer from another home health agency. (Discontinued July 1, 2010 — Reference Condition Code 47)

C = Readmission to Same home health Agency — the patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1, 2010)

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

E = Transfer from ambulatory surgical center

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

G = Transfer from a Designated Disaster Alternate Care Site (Eff. 7/1/20)

For Newborn Type of Admission

1 = Normal delivery — a baby delivered without complications

2 = Premature delivery — a baby delivered with time and/or weight factors qualifying it for premature status

3 = Sick baby — a baby delivered with medical complications, other than those relating to premature status

4 = Extramural birth — a baby delivered in a nonsterile environment

5 = Reserved for national assignment

6 = Reserved for national assignment

7 = Reserved for national assignment

8 = Reserved for national assignment

9 = Information not available

COMMENT: —
**CLM_SRVC_CLSFCTN_TYPE_CD**

**LABEL:** Claim Service Classification Type Code

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

**SHORT NAME:** TYPESRVC

**LONG NAME:** CLM_SRVC_CLSFCTN_TYPE_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**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)

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
6 = Freestanding Non-residential Opioid Treatment Programs (eff. 1/2021)

**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 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: the facility type (CLM_FAC_TYPE_CD) and the service classification type code (CLM_SRVC_CLSFCTN_TYPE_CD).
**CLM_SRVC_FAC_ZIP_CD**

**LABEL:** Claim service facility ZIP code (where service was provided)

**DESCRIPTION:** ZIP code where service was provided, as indicated on the claim.

**SHORT NAME:** CLM_SRVC_FAC_ZIP_CD

**LONG NAME:** CLM_SRVC_FAC_ZIP_CD

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** NCH

**VALUES:** XXXXXXXXXX

**COMMENT:** —
**CLM_SS_OUTLIER_STD_PYMT_AMT**

**LABEL:** Claim Short Stay Outlier (SSO) Standard Payment Amount

**DESCRIPTION:** This variable is the standard payment amount for long-term care hospitals (LTCH) under the Medicare prospective payment system (PPS), which is based on the MS-LTC-DRG with the short stay outlier (SSO) adjustment.

This amount does not include any other applicable outlier payment amount.

**SHORT NAME:** CLM_SS_OUTLIER_STD_PYMT_AMT

**LONG NAME:** CLM_SS_OUTLIER_STD_PYMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Applies only to inpatient (LTCH) claims. This field is new in October 2015.

For a LTCH PPS claim, only one of four fields will be populated (CLM_SITE_NTRL_PYMT_CST_AMT, CLM_SITE_NTRL_PYMT_IPPS_AMT, CLM_FULL_STD_PYMT_AMT, or CLM_SS_OUTLIER_STD_PYMT_AMT) as they are mutually exclusive (i.e., only one of the 4 fields will have a non-zero value). The field with the non-zero value is included in the Claim Payment Amount field.

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**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:** THRU_DT

**LONG NAME:** CLM_THRU_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** For home health prospective payment system (PPS) claims, the 'from' date and the 'thru' date on the RAP (Request for Anticipated Payment) initial claim match.

The "thru" date on the claim may not always represent the last date of services, particularly for home health or hospice care. To obtain the date corresponding with the cessation of services (or discharge date) use the discharge date from the claim (variable called NCH_BENE_DSCHRG_DT; **NOTE:** this variable is not available for home health claims).

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

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**CLM_TOT_CHRG_AMT**

**LABEL:** Claim Total Charge Amount

**DESCRIPTION:** The total charges for all services included on the institutional claim.

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

**SHORT NAME:** TOT_CHRG

**LONG NAME:** CLM_TOT_CHRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** —
**CLM_TOT_PPS_CPTL_AMT**

**LABEL:** Claim Total PPS Capital Amount

**DESCRIPTION:** The total amount that is payable for capital for the prospective payment system (PPS) claim.

This is the sum of the capital hospital specific portion, federal specific portion, outlier portion, disproportionate share portion, indirect medical education portion, exception payments, and hold harmless payments.

**SHORT NAME:** PPS_CPTL

**LONG NAME:** CLM_TOT_PPS_CPTL_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).

**CLM_TRTMT_AUTHRZTN_NUM**

**LABEL:** Claim Treatment Authorization Number

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

**SHORT NAME:** CLM_TRTMT_AUTHRZTN_NUM

**LONG NAME:** CLM_TRTMT_AUTHRZTN_NUM

**TYPE:** CHAR

**LENGTH:** 18

**SOURCE:** NCH

**VALUES:** XXXXXXX

**COMMENT:** This number is used by the fiscal intermediary and the Peer Review Organization.
**CLM_UNCOMPD_CARE_PMT_AMT**

**LABEL:** Claim Uncompensated Care Payment Amount

**DESCRIPTION:** This field identifies the payment for disproportionate share hospitals (DSH). It represents the uncompensated care amount of the payment.

**SHORT NAME:** CLM_UNCOMPD_CARE_PMT_AMT

**LONG NAME:** CLM_UNCOMPD_CARE_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field applies only to inpatient claims.

These payments were authorized as part of Section 3133 of the Affordable Care Act (ACA).
**CLM_UTLZTN_DAY_CNT**

**LABEL:** Claim Medicare Utilization Day Count

**DESCRIPTION:** On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days.

It excludes any days classified as non-covered, leave of absence days, and the day of discharge or death.

**SHORT NAME:** UTIL_DAY

**LONG NAME:** CLM_UTLZTN_DAY_CNT

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**CLM_VAL_AMT**

**LABEL:** Claim Value Amount

**DESCRIPTION:** The amount related to the condition identified in the claim value code (variable called CLM_VAL_CD) which was used by the intermediary to process the institutional claim.

**SHORT NAME:** VAL_AMT

**LONG NAME:** CLM_VAL_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** —
**CLM_VAL_CD**

**LABEL:** Claim Value Code

**DESCRIPTION:** The code indicating a monetary condition which was used by the intermediary to process an institutional claim.

The associated monetary value is in the claim value amount field (CLM_VAL_AMT).

**SHORT NAME:** VAL_CD

**LONG NAME:** CLM_VAL_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

01 = Most Common Semi-Private Rate — to provide for the recording of hospital's most common semi-private rate

02 = Hospital Has No Semi-Private Rooms — entering this code requires $0.00 amount

03 = Reserved for national assignment

04 = Inpatient professional component charges which are combined billed — for use only by some all-inclusive rate hospitals

05 = Professional component included in charges and also billed separately to carrier — for use on Medicare and Medicaid bills if the state requests this information

06 = Medicare blood deductible — total cash blood deductible (Part A blood deductible)

07 = Medicare cash deductible reserved for national assignment

08 = Medicare Part A lifetime reserve amount in first calendar year — lifetime reserve amount charged in the year of admission

09 = Medicare Part A coinsurance amount in the first calendar year — coinsurance amount charged in the year of admission

10 = Medicare Part A lifetime reserve amount in the second calendar year — lifetime reserve amount charged in the year of discharge where the bill spans two calendar years

11 = Medicare Part A coinsurance amount in the second calendar year — coinsurance amount charged in the year of discharge where the bill spans two calendar years

12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment
13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment

14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment

15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment

16 = That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment

17 = Operating Outlier amount — Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry)

18 = Operating Disproportionate share amount — providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry)

19 = Inpatient Use. Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry

Outpatient Use. The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider’s reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types

20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount

21 = Catastrophic — Medicaid — eligibility requirements to be determined at state level

22 = Surplus — Medicaid — eligibility requirements to be determined at state level

23 = Recurring monthly income — Medicaid — eligibility requirements to be determined at state level

24 = Medicaid rate code — Medicaid — eligibility requirements to be determined at state level
25 = Offset to the Patient Payment Amount (Prescription Drugs) — prescription drugs paid for out of a long-term care facility resident/patient’s fund in the billing period submitted (Statement Covers Period)

26 = Prescription Drugs Offset to Patient (Payment amount — hearing and ear services) hearing and ear services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement covers period)

27 = Offset to the Patient (Payment Amount — Vision and Eye Services) — vision and eye services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period)

28 = Offset to the Patient (Payment Amount — Dental Services) — dental services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period)

29 = Offset to the Patient (Payment Amount — Chiropractic Services) — chiropractic services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period)

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

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

32 = Multiple patient ambulance transport — the number of patients transported during one ambulance ride to the same destination. (eff. 4/1/2003)

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

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

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

37 = Pints of blood furnished — total number of pints of whole blood or units of packed red cells furnished to the patient

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

39 = Pints of blood replaced — the total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient
40 = New coverage not implemented by HMO — amount shown is for inpatient charges covered by HMO. (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO)

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

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

43 = Disabled bene under age 65 with LGHP — amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill

44 = Amount provider agreed to accept from primary payer when amount less than charges, but more than payment received — when a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due

45 = Accident Hour — the hour the accident occurred that necessitated medical treatment

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

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

48 = Hemoglobin reading — the patient's most recent hemoglobin reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during the billing cycle

49 = Hematocrit reading — the patient's most recent hematocrit reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing cycle

50 = Physical therapy visits — indicates the number of physical therapy visits from onset (at billing provider) through this billing period

51 = Occupational therapy visits — indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period

52 = Speech therapy visits — indicates the number of speech therapy visits from onset (at billing provider) through this billing period

53 = Cardiac rehabilitation — indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period
54 = New birth weight in grams — actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of ‘4’ and on other claims as required by law

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

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

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

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

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

60 = HHA branch MSA — MSA in which HHA branch is located

61 = Location of HHA service or hospice service — the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider. NOTE: HHA claims with a thru date on or before 12/31/2005, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/2005, the value code amount field reflects the CBSA code

62 = Payer only — on Type of Bill 032x: HH Visits Part A — the number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act. On Type of Bills 081x or 082x: Number of High Routine Home Care Days -Days that fall within the first 60 days of a routine home care hospice claim

63 = Payer only — on Type of Bill 032x: HH visits — Part B — the number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act. On Type of Bills 081x or 082x: Number of Low Routine Home Care Days -Days that come after the first 60 days of a routine home care hospice claim.

64 = Payer only HH Reimbursement — Part A — the dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
65 = Payer only HH Reimbursement — Part B — the dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by 1812(a)(3) of the Social Security Act.

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

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

68 = EPO drug — number of units of EPO administered relating to the billing period.

69 = State charity care percent — code indicates the percentage of charity care eligibility for the patient.

70 = Interest amount — (providers do not report this.) Report the amount applied to this bill.

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

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

73 = Sequestration adjustment amount.

74 = Low volume hospital payment amount.

75 = Prior covered days for an interrupted stay.

76 = Provider’s interim rate — report provider’s percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only). An interim rate of 50 percent is entered as follows: 50.00.

77 = New technology add-on payment amount — amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary. (eff. 4/1/2003, under inpatient PPS).

78 = Off-site zip code — when the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 012X, 013X, 014X, 022X, 023X, 034X, 072X, 074X, 075X, 081X, 082X, and 085X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 = Total payments for services applicable to the ESRD — the Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.
80 = Covered days — the number of days covered by the primary payer

81 = Non-covered days — days of care not covered by the primary payer

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

83 = Lifetime reserve days — under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness

84 = Medicare lifetime reserve amount — in the third or greater calendar years (eff. 1/7/2013)

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

86 = Invoice Cost (for CAR T-cells) (eff. 04/2019, term. 3/2020)

87 = Gene Therapy Invoice Cost (eff. 4/2020)

88 = Allogeneic Stem Cell Transplant — number of related donors’ evaluation (eff. 7/2020)

89 = Allogeneic Stem Cell Transplant — total all-inclusive donor charges (eff. 7/2020)

90 = Cell Therapy Invoice Cost (eff. 4/2020)

91 = Charges for Kidney Acquisition (eff. 10/1/2021)

92–99 = Reserved for national assignment

A0 = Special Zip Code Reporting — five-digit zip code of the location from which the beneficiary is initially placed on board the ambulance (eff. 9/2001)

A1 = Deductible Payer A — the amount assumed by the provider to be applied to the patient’s deductible amount to the involving the indicated payer. (eff. 10/1993) — Prior value 0

A2 = Coinsurance Payer A — the amount assumed by the provider to be applied to the patient’s Part B coinsurance amount involving the indicated payer

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

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

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

A6 = Covered self-administered drugs — diagnostic study and other — the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637
A7 = Copayment A — the amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer

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

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

AA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) — the amount of regulatory surcharges, assessments, allowances, or health care related taxes pertaining to the indicated payer (eff. 10/2003)

AB = Other Assessments or Allowances (Payer A) — the amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003)

B1 = Deductible Payer B — the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff. 10/1993) — prior value 07

B2 = Coinsurance Payer B — the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer

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

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

BA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) — the amount of regulatory surcharges, assessments, allowances, or health care related taxes pertaining to the indicated payer (eff. 10/2003)

BB = Other Assessments or Allowances (Payer B) — the amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003)

C1 = Deductible Payer C — the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff. 10/1993) — prior value 07

C2 = Coinsurance Payer C — the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer

C3 = Estimated Responsibility Payer C

C7 = Copayment C — the amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer
CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) — the amount of regulatory surcharges, assessments, allowances, or health care related taxes pertaining to the indicated payer (eff. 10/2003)

CB = Other Assessments or Allowances (Payer C) — the amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003)

D3 = Estimated Responsibility Patient — the amount estimated by the provider to be paid by the indicated patient

D4 = Clinical Trial Number Assigned by NLM/NIH — eight-digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 1/1/2007)

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

D6 = Total number of minutes of dialysis provided during the billing period (eff. 1/1/2021)

E1 = Deductible Payer D

E3 = Estimated Responsibility Payer D

F1 = Deductible Payer E

F2 = Coinsurance Payer E

F3 = Estimated Responsibility Payer E

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

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

G1 = Deductible Payer F

G2 = Coinsurance Payer F

G3 = Estimated Responsibility Payer F

G8 = Facility where inpatient hospice service is delivered — MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (eff. 1/1/08)

GA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer F

P0 = Reserved for public health data reporting

P1 = Heart Rate (eff. 7/1/2019)

P2 = Blood Pressure – Systolic (eff. 7/1/2019)

P3 = Blood Pressure – Diastolic (eff. 7/1/2019)

Q0 = Pioneer Accountable Care Organization (ACO) non-model payment or Next Generation ACO non-model payment

Q1 = Pioneer ACO model payment amount including reduction or NG ACO payment amount including reduction

Q2 = Hospice claim paid from Part B Trust Fund

Q3 = Prior Authorization 25% Penalty
Q4 = Pennsylvania (PA) Rural Health Exclusion — Physician Services Claim Reimbursement
Q5 = Electronic health record (EHR) Reduction
Q6 = PQR5
Q7 = Islet Add-On Payment Amount (eff. 10/2016)
Q8 = Total Transitional Drug Add-On Payment Adjustment (TDAPA) Amount (eff. 1/2018)
Q9 = Medicare Advantage (MA) Plan Amount (eff. 10/2014)
QA = PHP partial week input
QB = ESRD Treatment Choices (ETC) Model: Home Dialysis Payment Adjustment (HDPA) total bonus paid
QC = OCM+ Payment Adjustment Amount (payer only) — (eff. 1/2020)
QD = Device credit
QE = ET3 Model – ET3 15% bonus payment
QF = HHA - LATE-SUB-PENALTY-AMT
QG = Total Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Amount — used to capture the add-on payment (eff. 4/2021)
QH = Total TPNIES CRA Amount — used to capture the add-on payment. (payer only) (eff. 1/2022)
QI = Maryland Primary Care Program (MDPCP) Federally Qualified Health Center (FQHC) Demo — used to capture reduction amounts (payer only) (eff. 1/2022)
QJ = ESRD Treatment Choices (ETC) Facility Performance Payment Adjustment (PPA) (payer only) (eff. 7/2022)
QK = Maryland Waiver Kidney Acquisition Payment
QM = MIPS adjustment amount
QN = First APC pass-through device offset
QO = Second APC pass-through device offset
QP = Reserved for future use
QQ = Terminated procedure with pass-through device OR condition for device credit present
QR = First APC pass-through drug or biological offset
QS = Second APC pass-through drug or biological offset
QT = Third APC pass-through drug or biological offset
QU = Device credit with device offset
QV = Value Based Purchasing adjustment amount
QW = PHP partial week output
XX = Total charge amount for all Part A visits on RIC 'U' claims — for home health claims containing both Part A and Part B services. This code identifies the total charge amount for the Part A visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, and 057X). Code created internally in the NCHMQA system (eff. 10/31/2001 with HHPPS).

XY = Total Charge Amount for all Part B visits on RIC 'U' claims — for home health claims containing both Part A and Part B services. This code identifies the total charge amount for the Part B visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, and 057X). Code created internally in the NCHMQA system (eff. 10/31/2001 with HHPPS).

XZ = Total Charge Amount for all Part B non-visit charges on the RIC 'U' claims — for home health claims containing both Part A and Part B services, this code identifies the total charge amount for the Part B non-visit charges. Code created internally in the NCHMQA system (eff. 10/31/2001 with HHPPS).

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

Y2 = Part B demo payment — portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.

Y3 = Part B coinsurance — amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

Y4 = Conventional Provider Payment Amount for Non-Demonstration Claims — this the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass-through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5 = Part B deductible, applicable for a Model 4 demonstration 64 claims

Z9 = COVID-19 PHE end date

COMMENT: —
**CLM_VBP_ADJSTMT_PCT**

**LABEL:** Claim VBP Adjustment Percent

**DESCRIPTION:** Under the Hospital Value Based Purchasing (HVBP) program, an adjustment is made to the base operating DRG amount for certain inpatient prospective payment system (IPPS) hospitals — based on their Total Performance Score (TPS).

**SHORT NAME:** CLM_VBP_ADJSTMT_PCT

**LONG NAME:** CLM_VBP_ADJSTMT_PCT

**TYPE:** NUM

**LENGTH:** 15

**SOURCE:** NCH

**VALUES:** X.XX

**COMMENT:** This initiative began in fourth quarter of 2013 (i.e., beginning of federal fiscal year 14 [FY14]). This field was new in 2013 and is null/missing for all previous years.

The HVBP applies only to subsection (d) IPPS hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (reference CLM_VBP_PRTCPNT_IND_CD). This percentage reduction is applied to the base operating DRG amount, depending on their TPS (which is the Value Based Purchasing Score), as required by the Affordable Care Act (ACA). The percentages change each FY.

Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

The actual dollar amount of the adjustment that applied to the claim is found in the variable called CLM_VBP_ADJSTMT_PMT_AMT.

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**CLM_VBP_ADJSTMT_PMT_AMT**

**LABEL:** Claim Value-Based Purchasing Adjustment Payment Amount

**DESCRIPTION:** This field represents the Hospital Value Based Purchasing (HVBP) Amount.

This could be an additional payment on the claim or a reduction, depending on the hospital’s performance score.

**SHORT NAME:** CLM_VBP_ADJSTMT_PMT_AMT

**LONG NAME:** CLM_VBP_ADJSTMT_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX (may be a negative value)

**COMMENT:** This initiative began in fourth quarter of 2013 (i.e., beginning of federal fiscal year 14 [FY14]). This field was new in 2013 and is null/missing for all previous years.

The HVBP applies only to subsection (d) inpatient prospective payment system (IPPS) hospitals. There is a variable that indicates whether the hospital was excluded from HVBP (reference CLM_VBP_PRTCPNT_IND_CD).

This amount is based on a VBP adjustment percent (variable called CLM_VBP_ADJSTMT_PCT) that is applied to the base operating DRG amount, depending on the hospital’s Total Performance Score (TPS), which is the Value Based Purchasing Score.

HVBP is required by the Affordable Care Act (ACA). The percentages change each FY. Additional information is available on the CMS "Hospital Value-Based Purchasing" website.
**CLM_VBP_PRTCPNT_IND_CD**

**LABEL:** Claim Value-Based Purchasing (VBP) Participant Indicator Code

**DESCRIPTION:** This field is the code used to identify a reason a hospital is excluded from the Hospital Value Based Purchasing (HVBP) program.

**SHORT NAME:** CLM_VBP_PRTCPNT_IND_CD

**LONG NAME:** CLM_VBP_PRTCPNT_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

- Y = Participating in Hospital Value Based Purchasing
- N = Not participating in Hospital Value Based Purchasing
- Null/missing = same as 'N'

**COMMENT:**

The ACA (Section 3001) excludes from the HVBP hospitals that meet certain conditions. Additional information is available on the CMS "Hospital Value-Based Purchasing" website.

This initiative began in fourth quarter of 2013 (i.e., beginning of federal fiscal year 14).

This field was new in 2013, and is null/missing for all previous years.

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**CPO_ORG_NPI_NUM**

**LABEL:** CPO Organization NPI Number

**DESCRIPTION:** The National Provider Identifier (NPI) number of the home health agency (HHA) or hospice rendering Medicare services during the period the physician is providing care plan oversight (CPO).

**SHORT NAME:** CPO_ORG_NPI_NUM

**LONG NAME:** CPO_ORG_NPI_NUM

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.
**CPO_PRVDR_NUM**

**LABEL:** Care Plan Oversight (CPO) Provider Number

**DESCRIPTION:** The National Provider Identifier (NPI) number of the home health agency (HHA) or hospice rendering Medicare services during the period the physician is providing care plan oversight (CPO).

**SHORT NAME:** CPO_PRVDR_NUM

**LONG NAME:** CPO_PRVDR_NUM

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.
**DEMO_ID_NUM**

**LABEL:** Demonstration number

**DESCRIPTION:** The number assigned to identify a CMS demonstration project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

**SHORT NAME:** DEMO_ID_NUM

**LONG NAME:** DEMO_ID_NUM

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

01 = Nursing Home Case-Mix and Quality Demo
02 = National HHA Prospective Payment Demo
03 = Telemedicine Waiver Demo (retired)
04 = United Mine Workers of America (UMWA) Managed Care Demo
05 = Medicare Choices (MCO encounter data) demo
06 = Medicare Participating Heart Bypass Center Demo
07 = Participating Centers of Excellence (retired)
08 = Provider Partnership Demo (retired) 09 = Colorado Integrated Care and Financing Project
10 = Community Nursing Organization Demo
11 = Consumer Directed DME Demo
12 = Competitive Bidding for Clinical Labs (non-MMA demo)
13 = Competitive Bidding for DME Demo
14 = Competitive Pricing — open enrollment demo (non-MMA)
15 = ESRD Managed Care (MCO encounter data) demo (retired)
16 = Utah All Payer Graduate Medical Education demo
17 = Group Specific Volume Performance Standards
18 = Medicaid Working Group Dual eligibles
19 = Minnesota Senior Health options
20 = Municipal Health Services Program
21 = New England Dual Eligible Waiver Project
22 = PACE
23 = Seattle Outlier Pool
24 = SHMO II
25 = VA Medicare Subvention Demo
26 = Wisconsin Partnership Demo
27 = On Lok
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<td>Encounter Data (not a demo)</td>
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<td>A/B Rebilling Demonstration — rebilled claims due to auditor denials (OFM) (retired 1/2023)</td>
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<tr>
<td>66</td>
<td>A/B Rebilling Demonstration — rebilled claims due to provider self-audit after claims submission/payment (retired 1/2023)</td>
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</table>
67 = A/B Rebilling Demonstration — rebilled claims due to provider self-audit after the patient has been discharged but prior to payment (retired 1/2023)

68 = SNF Qualifying Stay — Pioneer ACO

69 = Advance Payment ACO Model

70 = Electrical Workers Insurance Fund claims (EWIF)

71 = IVIG (Intravenous Immunoglobulin) Demo

72 = Implementing Payment Changes for home health Travel Reimbursement Changes for FCHIP.

73 = Medicare Care Choices Model

74 = Next Generation ACO Model

75 = Coordinated Quality Care — Comprehensive Care for Joint replacement (CCJR)

76 = Million Hearts CVD Risk Reduction Model

77 = Shared Savings Program (used in FISS and CWF to bypass the SNF 3-day requirement)78 = Comprehensive Primary Care Plus (CPC+) Model — MCS analysis

79 = Acute Myocardial Infarction (AMI) Episode Payment Model (EPM)

80 = Coronary Artery Bypass Graft (CABG) Episode Payment Model (EPM)

81 = Surgical Hip and Femur Fracture Treatment (SHFFT) Episode Payment Model (EMP)

82 = Medicare Diabetes Prevention Program (MDPP)

83 = Maryland Primary Care Program (MDPCP) Federally Qualified Health Center (FQHC) (eff. 1/2022). Previously was Maryland All Payer Model. This is the 3rd iteration of the Maryland All-Payer Model. This latest iteration encompasses Maryland Primary Care Program (MDPCP)

84 = Diabetes Prevention Program Virtual Model Test

85 = Comprehensive ESRD Care (CEC) Model

86 = Bundled Payments for Care Improvement (BPCI) — Advanced

87 = Radiation Oncology Bundled Payments

88 = Shared Savings Program (TELEHEALTH waiver)

89 = Vermont all-payer (VT ACO model)

91 = Emergency Triage, Treat and Transport (ET3)

92 = Direct Contracting (DC) Model

93 = Comprehensive Kidney Care Contracting (CKCC)

94 = ESRD Treatment Choices (ETC)

95 = Oncology Care Model Plus (OCM+)

96 = Primary Care First (PCF) Seriously Ill Population (SIP) Model

97 = Kidney Care First (KCF)

98 = The Pennsylvania Rural Health Model (PARHM)
99 = Opioid Use Disorder (OUD) Treatment Demonstration Program
A1 = Direct contracting (GEO)
A2 = Community Health Access and Rural Transformation Model (CHART)

A3 = Enhancing Oncology Model
A4 = Maryland Total Cost of Care Model

COMMENT: —

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DEMO_INFO_TXT

LABEL: Demonstration information text

DESCRIPTION: This is a text field that contains information related to the demonstration.

For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

SHORT NAME: DEMO_INFO_TXT

LONG NAME: DEMO_INFO_TXT

TYPE: CHAR

LENGTH: 15

SOURCE: NCH

VALUES: —

COMMENT: When the Demo ID = 01 (RUGS) — the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (home health demo) — the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'

Demo ID = 03 (Telemedicine demo) — text field will contain the HCPCS code. If the required HCPCS is not shown, then the text field will reflect 'INVALID'

Demo ID = 04 (UMWA) — text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present, then the text field will reflect 'INVALID'

Demo ID = 05 (CHOICES) — the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'

Demo ID = 15 (ESRD Managed Care) — text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number does not present the field will reflect 'INVALID'

Demo ID = 38 (Physician Encounter Claims) — text field will contain the MCO plan number. When MCO plan number is not present the field will reflect 'INVALID'

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**DMERC_LINE_FRGN_ADR_IND**

**LABEL:** Line Foreign Address Indicator

**DESCRIPTION:** Line Foreign Address Indicator on the durable medical equipment (DME) claim line

**SHORT NAME:** DMERC_LINE_FRGN_ADR_IND

**LONG NAME:** DMERC_LINE_FRGN_ADR_IND

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:** EX = Expatriate Beneficiary

**COMMENT:** This field is used to identify claims for expatriate beneficiaries (beneficiary whose permanent address is outside the U.S.) who purchased DMEPOS items that were furnished in the United States.

This field was new in July 2016.
**DMERC_LINE_MTUS_CD**

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

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

**SHORT NAME:** UNIT_IND

**LONG NAME:** DMERC_LINE_MTUS_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

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

**NOTE:** This problem has been corrected — no date on when the correction became effective.

**COMMENT:** —
**DMERC_LINE_MTUS_CNT**

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

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

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

**SHORT NAME:** DME_UNIT

**LONG NAME:** DMERC_LINE_MTUS_CNT

**TYPE:** NUM

**LENGTH:** 11

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** Prior to Version ‘J,’ this field was S9(3)
**DMERC_LINE_PRCNG_STATE_CD**

**LABEL:** DMERC Line Pricing State Code (SSA)

**DESCRIPTION:** The 2-digit SSA state code where the durable medical equipment (DME) supplier was located; used by the Medicare Administrative Contractor (MAC) for pricing the service.

**SHORT NAME:** PRCNG_ST

**LONG NAME:** DMERC_LINE_PRCNG_STATE_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

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<td>South America</td>
</tr>
<tr>
<td>63</td>
<td>U.S. Possessions</td>
</tr>
<tr>
<td>64</td>
<td>American Samoa</td>
</tr>
</tbody>
</table>
65 = Guam
97 = Northern Marianas
98 = Guam

99 = Unknown or if county code = 000 then this is American Samoa

COMMENT: —
DMERC_LINE_SCRN_SVGS_AMT

LABEL: DMERC Line Screen Savings Amount

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

SHORT NAME: SCRNSVGS

LONG NAME: DMERC_LINE_SCRN_SVGS_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —

^ Back to TOC ^
**DMERC_LINE_SUPPLR_TYPE_CD**

**LABEL:** DMERC Line Supplier Type Code

**DESCRIPTION:** The type of DMERC supplier.

**SHORT NAME:** SUP_TYPE

**LONG NAME:** DMERC_LINE_SUPPLR_TYPE_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

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

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

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

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

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

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

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

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

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

**COMMENT:** —

[^ Back to TOC ^]
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
<th>Type</th>
<th>Length</th>
<th>Source</th>
<th>Values</th>
<th>Comment</th>
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<tr>
<td>DMERC_OXGN_EQUIP_INITL_DT</td>
<td>The initial date for oxygen equipment.</td>
<td>DATE</td>
<td>8</td>
<td>NCH</td>
<td>—</td>
<td>This field is not populated before 2023. This is to support the elimination of the Certificate of Medical Necessity (CMN).</td>
</tr>
</tbody>
</table>
**DMERC_OXGN_EQUIP_PRVS_DT**

**LABEL:** Oxygen Equipment Previous Date

**DESCRIPTION:** The previous date for oxygen equipment. This date applies to claim lines that have a backdated initial date indicator (DMERC_OXGN_INITL_DT_CD = B).

**SHORT NAME:** DMERC_OXGN_EQUIP_PRVS_DT

**LONG NAME:** DMERC_OXGN_EQUIP_PRVS_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** This field is not populated before 2023. This is to support the elimination of the Certificate of Medical Necessity (CMN).
**DMERC_OXGN_INITL_DT_CD**

**LABEL:** Oxygen Equipment Initial Date Code

**DESCRIPTION:** The initial date indicator for oxygen equipment.

**SHORT NAME:** DMERC_OXGN_INITL_DT_CD

**LONG NAME:** DMERC_OXGN_INITL_DT_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- I = Initial Date
- B = Backdate Initial Date
- R = Replacement Item
- Null/missing = no Oxygen Equipment.

**COMMENT:** This field is not populated before 2023. This is to support the elimination of the Certificate of Medical Necessity (CMN).
DOB_DT

LABEL: Date of Birth from Claim

DESCRIPTION: The beneficiary's date of birth.

SHORT NAME: DOB_DT

LONG NAME: DOB_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —
DSH_OP_CLM_VAL_AMT

LABEL: Operating Disproportionate Share (DSH) Amount

DESCRIPTION: This is one component of the total amount that is payable on prospective payment system (PPS) claims and reflects the DSH (disproportionate share hospital) payments for operating expenses (such as labor) for the claim.

There are two types of DSH amounts that may be payable for many PPS claims; the other type of DSH payment is for the DSH capital amount (variable called CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT).

Both operating and capital DSH payments are components of the PPS, as well as numerous other factors.

SHORT NAME: DSH_OP

LONG NAME: DSH_OP_CLM_VAL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/).


DERIVATION RULES: If there is a value code '18' (i.e., in the value code file, if the VAL_CD='18') then this dollar amount (VAL_AMT) is used to populate this field."
### EHR_PGM_RDCTN_IND_SW

**LABEL:** Claim Electronic Health Records (EHR) Program Reduction Indicator Switch  
**DESCRIPTION:** This field is a switch that identifies which hospitals are Electronic Health Records (EHR) meaningful users and distinguishes hospitals that will have a payment penalty for not being meaningful users.  
**SHORT NAME:** EHR_PGM_RDCTN_IND_SW  
**LONG NAME:** EHR_PGM_RDCTN_IND_SW  
**TYPE:** CHAR  
**LENGTH:** 1  
**SOURCE:** NCH  
**VALUES:**  
- Y = hospital is subject to a reduction under the EHR program  
- Blank = not applicable  
**COMMENT:** This field is new in October 2014. This field only applies to inpatient claims.
EHR_PYMT_ADJSTMT_AMT

LABEL: Claim Electronic Health Record (EHR) Payment Adjustment Amount

DESCRIPTION: The claims adjustment payment amount for Hospitals that are not meaningful users of certified Electronic Health Record (EHR) technology.

SHORT NAME: EHR_PYMT_ADJSTMT_AMT

LONG NAME: EHR_PYMT_ADJSTMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: This field was new in 2012 and is null/missing for all previous years.
**ESRD_TRTMT_CHS_IND_CD**

**LABEL:** End-Stage Renal Disease (ESRD) Treatment Choices Demonstration Indicator Code

**DESCRIPTION:** The type of ESRD treatment Choices (ETC) Model (Demo code 94).

**SHORT NAME:** ESRD_TRTMT_CHS_IND_CD

**LONG NAME:** ESRD_TRTMT_CHS_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- H or blank = Home Dialysis Payment Adjustment (HDPA) only
- P = Performance Payment Adjustment (PPA) only
- B = HDPA and PPA

**COMMENT:** The two types are, Home Dialysis Payment Adjustment (HDPA) and Performance Payment Adjustment (PPA). This field is not populated prior to 2021.
**FI_CLM_ACTN_CD**

**LABEL:** FI or MAC Claim Action Code

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

**SHORT NAME:** ACTIONCD

**LONG NAME:** FI_CLM_ACTN_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- 1 = Original debit action (always a 1 for all regular bills)
- 5 = Force action code 3 (secondary debit adjustment)
- 8 = Benefits refused

**COMMENT:** —
**FI_CLM_PROC_DT**

**LABEL:** FI Claim Process Date  

**DESCRIPTION:** The date the fiscal intermediary completes processing and releases the institutional claim to the CMS common working file (CWF; stored in the NCH).

**SHORT NAME:** FI_CLM_PROC_DT  

**LONG NAME:** FI_CLM_PROC_DT  

**TYPE:** DATE  

**LENGTH:** 8  

**SOURCE:** NCH  

**VALUES:** —  

**COMMENT:** —
**FI_NUM**

**LABEL:** FI or MAC Number

**DESCRIPTION:** The identification number assigned by CMS to a fiscal intermediary (FI) authorized to process institutional claim records.

Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

**SHORT NAME:** FI_NUM

**LONG NAME:** FI_NUM

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** Different FI/MAC carriers are under contract with CMS at different times.

Reference the CMS website for MAC Contract Status (for example):
https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/who-are-the-macs#MapsandLists

**Fiscal Intermediary Numbers (as of October 2021):**

00010 Alabama BC — Alabama (term. 05/2009)(replaced with MAC #10101)
00011 Alabama BC — Iowa (term. 10/2007) replaced by MAC # 03401)
00011 Cahaba — (RHHI) (term. 06/2011) replaced by MAC # 03401 )
00012 Iowa (terminated) replaced by MAC # 05101)
00012 Arizona — Noridian — J3 A MAC (AZA)(term. 05/2008)
00020 Arkansas BC — Arkansas
00021 Arkansas BC — Rhode Island(term. 05/2009)
00030 Arizona BC (term. 09/2007)(replaced by MAC # 03101)
00040 California BC (term. 11/2000)
00090 Florida BC (term. 02/2009)(replaced with MAC #09101)
00101 Georgia BC (term. 05/2009)(replaced with MAC #10201)
00130 Indiana BC/Administer Federal (term. 7/22/2012)(replaced with MAC # 08101)
00131 Illinois — Anthem
00140 Iowa — Wellmark (term. 05/2000)
00150 Kansas BC (term. 02/2008)(replaced with MAC # 05201)
00160 Kentucky — Anthem (term. 4/30/2011)(replaced with MAC # 15101)
00180 Maine BC (term. 05/2009)(replaced with MAC #14004 and 14101)
00180 Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island (Maine RHHI)(term. 05/2009)(replaced with MAC #14004 and 14101 )
00181 Massachusetts — Maine BC (term. 05/2009)
00190 Carefirst of Maryland (term. 09/2005)
00230 Mississippi BC
00230 Trispan Health Services (LA-MS) (term. 09/2009)(previously also MOA)
00242 BCBS of MS (MOA) (term. 04/2008)(replaced with MAC # 05301)
00242 Missouri (terminated)(replaced with MAC # 05301)
00250 Montana BC (term. 11/2006)(replaced by MAC # 03201)
00260 Nebraska BC (term. 11/2007)(replaced with MAC # 05401)
00270 New Hampshire BC — New Hampshire, Vermont (term. 06/2009)(replaced with MAC #14501)
00280 New Jersey BC (term. 07/2000)
00308 Empire BC — New York, Connecticut, and Delaware (term. 11/2008)(replaced with MAC # 12101, 13201 and 13101)
00310 North Carolina BC (term. 09/2002)
00320 North Dakota BC — North Dakota (term. 12/1/2006)(replaced with MAC # 03301)
00322 North Dakota BC — Washington and Alaska
00323 North Dakota BC — Idaho, Oregon, and Utah (term. 11/2006)(replaced with MAC # 03501)
00325 Noridian — Idaho, Oregon
00332 Administar — Ohio Anthem — Ohio
00340 Oklahoma BC (term. 02/2008)(replaced with MAC # 04301)
00350 Regence — Oregon, Idaho, Utah (term. 11/2005)
00363 Pennsylvania/Highmark — Veritus (term. 07/2008)
00366 Highmark (MD and DC) — Part A (eff. 10/2005)(term. 07/2008)
00370 Rhode Island BC (term. 03/2004)(replaced with MAC #14401)
00380 South Carolina BC — South Carolina (term. 01/2011)(replaced with MAC #11004 and 11201)
00380 Palmetto GBA — AL, AR, GA, FL, IL, IN, KY, LA, MS, MN, NC, OK, OH, SC, TN, TX (term. 01/2011)
00382 South Carolina BC — North Carolina (term. 10/2010)(replaced with MAC #11501)
00390 Riverbend BC — New Jersey, Tennessee (term. 08/2009)(replaced with MAC # 12001 and 10301)
00400 Texas BC — Colorado, New Mexico, Texas (term. 05/2008)(replaced with MAC #04101, 04201, 04401 — refer below)
00410 Utah BC (term. 09/2000)
00450 Wisconsin BC — Wisconsin
00450 Michigan, Minnesota, New Jersey, New York, Wisconsin (RHHI)
00452 Wisconsin BC — Michigan (term. 7/22/2012)(replaced with MAC # 08201)
00453 Wisconsin BC — Virginia and West Virginia(term. 05/2011)(replaced with MAC #11301 and 11401)
00454 Wisconsin BC — California, Hawaii, Nevada (RHHI)(term. 08/2008)(replaced by MAC #01101, 01201 and 01301 — refer below)
00460 Wyoming BC (term. 10/2006)(replaced by MAC # 03601)
00468 North Carolina BC/CPRTIVA (terminated)
01101 California (eff. 8/15/2008)(replaces FI #00454)
01111 California entire state — Noridian Healthcare Solutions
01201 Hawaii (eff. 8/15/2008)(replaces FI #00454)
01211 Guam, Hawaii, Northern Mariana Islands — Noridian Healthcare Solutions
01301 Nevada (eff. 8/15/2008)(replaces FI #00454)
01311 Nevada — Noridian Healthcare Solutions
01390 AETNA — Washington
01911 American Samoa, California — entire state, Guam, Hawaii, Nevada, Northern Mariana Islands — Noridian Healthcare Solutions
02101 Alaska (eff. 02/01/2012)
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<th>Description</th>
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<td>12301</td>
<td>Maryland (eff. 08/01/2008)</td>
</tr>
<tr>
<td>12401</td>
<td>New Jersey (eff. 9/1/2008)(replaces FI # 00390)</td>
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</table>
12501 Pennsylvania (eff. 08/01/2008)
12901 Novitas Solutions J12
13101 Connecticut (eff. 8/1/2008)(replaces FI #00308)
13201 NGS-New York (eff. 7/18/2008)(replaces FI #00308)
14014 Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont – National Government Services, Inc
14111 Maine — National Government Services, Inc
14211 Massachusetts — National Government Services, Inc.
14311 New Hampshire — National Government Services, Inc.
14411 Rhode Island — National Government Services, Inc.
14511 Vermont — National Government Services, Inc
15004 CGS Government Services (HHH B RHHI)(eff. 06/13/2011)
15101 Kentucky (eff. 10/17/2011)
15201 Ohio (eff. 10/17/2011)
50333 Travelers; Connecticut United Healthcare(term. 07/2000)
52280 NE — Mutual of Omaha
52280 Mutual of Omaha (NT) Note: Nebraska — 00260 (NE) and 52280 (NT)

COMMENT: —

^ Back to TOC ^
FINL_STD_AMT

LABEL: Claim Final Standard Payment Amount

DESCRIPTION: This amount further adjusts the standard Medicare Payment amount (field called PPS_STD_VAL_PYMT_AMT) by applying additional standardization requirements (e.g., sequestration).

SHORT NAME: FINL_STD_AMT

LONG NAME: FINL_STD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XX.XX

COMMENT: This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard Medicare payment amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the hospitals.

This field first appeared in inpatient claims in October 2014. For HHA claims, this field first appeared in July 2018 and is called PPS_STD_VAL_PYMT_AMT.
**FST_DGNS_E_CD**

**LABEL:** First Claim Diagnosis E Code

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

**SHORT NAME:** FST_DGNS_E_CD

**LONG NAME:** FST_DGNS_E_CD

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** Prior to version ‘J,’ this field was named: CLM_DGNS_E_CD.

Effective with Version ‘J,’ this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

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

**LABEL:** First Claim Diagnosis E Code Diagnosis Version Code (ICD-9 or ICD-10)

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

**SHORT NAME:** FST_DGNS_E_VRSN_CD

**LONG NAME:** FST_DGNS_E_VRSN_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** —

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

**COMMENT:** With 5010, the diagnosis and procedure codes were expanded to accommodate the future implementation of ICD-10.

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

LABEL: Gender Code from Claim

DESCRIPTION: The sex of a beneficiary.

SHORT NAME: GNDR_CD

LONG NAME: GNDR_CD

TYPE: CHAR

LENGTH: 1

SOURCE: SSA, RRB, EDB

VALUES: 0 = Unknown
1 = Male
2 = Female

COMMENT: —
### HAC_PGM_RDCTN_IND_SW

**LABEL:** Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Switch

**DESCRIPTION:** This field is a switch that identifies hospitals subject to a Hospital Acquired Conditions (HAC) reduction of what they would otherwise be paid under the inpatient prospective payment system (IPPS).

**SHORT NAME:** HAC_PGM_RDCTN_IND_SW

**LONG NAME:** HAC_PGM_RDCTN_IND_SW

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- Y = hospital subject to a reduction under the HAC Reduction Program
- N = hospital is not subject to a reduction under the HAC Reduction Program

**COMMENT:** This field is new in October 2014. This field only applies to inpatient claims.

For details on the CMS hospital readmission reduction program reference the CMS website: [http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html](http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html)
**HCPCS_1ST_MDFR_CD**

**LABEL:** HCPCS Initial Modifier Code

**DESCRIPTION:** A first modifier 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 claim.

**SHORT NAME:** MDFR_CD1

**LONG NAME:** HCPCS_1ST_MDFR_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
HCPCS_2ND_MDFR_CD

LABEL: HCPCS Second Modifier Code

DESCRIPTION: A second modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first modifier code to identify the revenue center or line-item service for the claim.

SHORT NAME: MDFR_CD2

LONG NAME: HCPCS_2ND_MDFR_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: —
**HCPCS_3RD_MDFR_CD**

**LABEL:** HCPCS Third Modifier Code

**DESCRIPTION:** A third modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first or second modifier codes to identify the revenue center or line-item services for the claim.

**SHORT NAME:** MDFR_CD3

**LONG NAME:** HCPCS_3RD_MDFR_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**HCPCS_4TH_MDFR_CD**

**LABEL:** HCPCS Fourth Modifier Code

**DESCRIPTION:** A fourth modifier to the Healthcare Common Procedure Coding System (HCPCS) procedure code to make it more specific than the first, second, or third modifier codes identify the revenue center or line-item services for the claim.

**SHORT NAME:** MDFR_CD4

**LONG NAME:** HCPCS_4TH_MDFR_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** This field is available only in the Hospital outpatient data file (no other claim types).
**HCPCS_CD**

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

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

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

**SHORT NAME:** HCPCS_CD

**LONG NAME:** HCPCS_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** Level I


**NOTE 1:** CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright.

Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Fifth Edition (CDT-5). These are five-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 five-position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in the level I or level II codes.
**NOTE 2:** This field may contain information regarding case-mix grouping that Medicare used to pay for SNF, home health, or IRF services. These groupings are sometimes known as Health Insurance prospective payment system (HIPPS) codes.

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

For home health claims, please also reference the revenue center APC/HIPPS code variable (REV_CNTR_APC_HIPPS_CD).
HPSA_SCRCTY_IND_CD

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

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

SHORT NAME: HPSASCCD

LONG NAME: HPSA_SCRCTY_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = HPSA
2 = Scarcity
3 = Both
5 = HPSA and HSIP
6 = PCIP
7 = HPSA and PCIP
Space = Not applicable

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

Prior to 10/3/2005, claims contained a modifier code to indicate the bonus payment. A 'QU' represented a HPSA bonus payment and an 'AR' represented a scarcity bonus payment. As of 1/1/2005, the modifiers were no longer being reported by the provider. NCH and NMUD were not ready to accept the new field until 10/3/2005.
<table>
<thead>
<tr>
<th>Short Name</th>
<th>Long Name</th>
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<tbody>
<tr>
<td>ICD_DGNS_CD1</td>
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<td>ICD_DGNS_CD24</td>
</tr>
<tr>
<td>ICD_DGNS_CD13</td>
<td>ICD_DGNS_CD25</td>
</tr>
</tbody>
</table>

**LABEL:** Claim Diagnosis Code

**DESCRIPTION:** The diagnosis code identifying the beneficiary's diagnosis.

**SHORT NAME:**

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

**LONG NAME:**

| ICD_DGNS_CD1 | ICD_DGNS_CD5 |
| ICD_DGNS_CD2 | ICD_DGNS_CD6 |
| ICD_DGNS_CD3 | ICD_DGNS_CD7 |
| ICD_DGNS_CD4 | ICD_DGNS_CD8 |
ICD_DGNS_CD9
ICD_DGNS_CD10
ICD_DGNS_CD11
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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: NCH
VALUES: —

COMMENT: For ICD-9 diagnosis codes, this is a 3–5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015, the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.

Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).
ICD_DGNS_E_CD1  ICD_DGNS_E_CD7
ICD_DGNS_E_CD2  ICD_DGNS_E_CD8
ICD_DGNS_E_CD3  ICD_DGNS_E_CD9
ICD_DGNS_E_CD4  ICD_DGNS_E_CD10
ICD_DGNS_E_CD5  ICD_DGNS_E_CD11
ICD_DGNS_E_CD6  ICD_DGNS_E_CD12

LABEL: Claim Diagnosis E Code

DESCRIPTION: The code used to identify the external cause of injury, poisoning, or other adverse effect.

SHORT NAME:
ICD_DGNS_E_CD1  ICD_DGNS_E_CD7
ICD_DGNS_E_CD2  ICD_DGNS_E_CD8
ICD_DGNS_E_CD3  ICD_DGNS_E_CD9
ICD_DGNS_E_CD4  ICD_DGNS_E_CD10
ICD_DGNS_E_CD5  ICD_DGNS_E_CD11
ICD_DGNS_E_CD6  ICD_DGNS_E_CD12

LONG NAME:
ICD_DGNS_E_CD1  ICD_DGNS_E_CD7
ICD_DGNS_E_CD2  ICD_DGNS_E_CD8
ICD_DGNS_E_CD3  ICD_DGNS_E_CD9
ICD_DGNS_E_CD4  ICD_DGNS_E_CD10
ICD_DGNS_E_CD5  ICD_DGNS_E_CD11
ICD_DGNS_E_CD6  ICD_DGNS_E_CD12

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: Effective with Version ‘J,’ this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

On October 1, 2015, the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.
<table>
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<th>SHORT NAME</th>
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<td>ICD_DGNS_VRSN_CD13</td>
<td>ICD_DGNS_VRSN_CD25</td>
</tr>
</tbody>
</table>

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

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

**SHORT NAME:**
ICD_DGNS_VRSN_CD11  ICD_DGNS_VRSN_CD19
ICD_DGNS_VRSN_CD12  ICD_DGNS_VRSN_CD20
ICD_DGNS_VRSN_CD13  ICD_DGNS_VRSN_CD21
ICD_DGNS_VRSN_CD14  ICD_DGNS_VRSN_CD22
ICD_DGNS_VRSN_CD15  ICD_DGNS_VRSN_CD23
ICD_DGNS_VRSN_CD16  ICD_DGNS_VRSN_CD24
ICD_DGNS_VRSN_CD17  ICD_DGNS_VRSN_CD25
ICD_DGNS_VRSN_CD18

TYPE: CHAR
LENGTH: 1
SOURCE: NCH
VALUES: Blank = ICD-9
9 = ICD-9
0 = ICD-10

COMMENT: On October 1, 2015, the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.
<table>
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</table>

**LABEL:** Claim Procedure Code

**DESCRIPTION:** The code that indicates the procedure performed during the period covered by the institutional claim.

**SHORT NAME:**

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ICD_PRCDR_CD12  ICD_PRCDR_CD20
ICD_PRCDR_CD13  ICD_PRCDR_CD21
ICD_PRCDR_CD14  ICD_PRCDR_CD22
ICD_PRCDR_CD15  ICD_PRCDR_CD23
ICD_PRCDR_CD16  ICD_PRCDR_CD24
ICD_PRCDR_CD17  ICD_PRCDR_CD25
ICD_PRCDR_CD18

TYPE: CHAR
LENGTH: 7
SOURCE: NCH
VALUES: —

COMMENT: Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services. ICD_PRCDR_CD1 is considered the primary procedure performed.
ICD_PRCDR_VRSN_CD1  ICD_PRCDR_VRSN_CD14
ICD_PRCDR_VRSN_CD2  ICD_PRCDR_VRSN_CD15
ICD_PRCDR_VRSN_CD3  ICD_PRCDR_VRSN_CD16
ICD_PRCDR_VRSN_CD4  ICD_PRCDR_VRSN_CD17
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ICD_PRCDR_VRSN_CD9  ICD_PRCDR_VRSN_CD22
ICD_PRCDR_VRSN_CD10 ICD_PRCDR_VRSN_CD23
ICD_PRCDR_VRSN_CD11 ICD_PRCDR_VRSN_CD24
ICD_PRCDR_VRSN_CD12 ICD_PRCDR_VRSN_CD25
ICD_PRCDR_VRSN_CD13

**LABEL:** Claim Procedure Code Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the procedure code is ICD-9 or ICD-10.

**SHORT NAME:**

ICD_PRCDR_VRSN_CD1  ICD_PRCDR_VRSN_CD14
ICD_PRCDR_VRSN_CD2  ICD_PRCDR_VRSN_CD15
ICD_PRCDR_VRSN_CD3  ICD_PRCDR_VRSN_CD16
ICD_PRCDR_VRSN_CD4  ICD_PRCDR_VRSN_CD17
ICD_PRCDR_VRSN_CD5  ICD_PRCDR_VRSN_CD18
ICD_PRCDR_VRSN_CD6  ICD_PRCDR_VRSN_CD19
ICD_PRCDR_VRSN_CD7  ICD_PRCDR_VRSN_CD20
ICD_PRCDR_VRSN_CD8  ICD_PRCDR_VRSN_CD21
ICD_PRCDR_VRSN_CD9  ICD_PRCDR_VRSN_CD22
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ICD_PRCDR_VRSN_CD11 ICD_PRCDR_VRSN_CD24
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ICD_PRCDR_VRSN_CD13
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ICD_PRCDR_VRSN_CD6  ICD_PRCDR_VRSN_CD19
ICD_PRCDR_VRSN_CD7  ICD_PRCDR_VRSN_CD20
ICD_PRCDR_VRSN_CD8  ICD_PRCDR_VRSN_CD21
ICD_PRCDR_VRSN_CD9  ICD_PRCDR_VRSN_CD22
ICD_PRCDR_VRSN_CD10 ICD_PRCDR_VRSN_CD23
ICD_PRCDR_VRSN_CD11 ICD_PRCDR_VRSN_CD24
ICD_PRCDR_VRSN_CD12 ICD_PRCDR_VRSN_CD25
ICD_PRCDR_VRSN_CD13

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

LABEL: Operating Indirect Medical Education (IME) Amount

DESCRIPTION: This is one component of the total amount that is payable on PPS claims, and reflects the IME (indirect medical education) payments for operating expenses (such as labor) for the claim.

There are two types of IME amounts that may be payable for many PPS claims; the other type of IME payment is for the IME capital amount (variable called CLM_PPS_CPTL_IME_AMT). Both operating and capital IME payments are components of the PPS, as well as numerous other factors.

SHORT NAME: IME_OP

LONG NAME: IME_OP_CLM_VAL_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: https://www.medpac.gov/document-type/payment-basic/)


Derivation Rules: If there is a value code '19' (i.e., in the value code file, if the VAL_CD='19') then this dollar amount (VAL_AMT) is used to populate this field.
**LINE_1ST_EXPNS_DT**

**LABEL:** Line First Expense Date

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

**SHORT NAME:** EXPNSDT1

**LONG NAME:** LINE_1ST_EXPNS_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —

[^ Back to TOC ^]
**LINE_ADJUST_GRP_CD**

**LABEL:** Line Adjustment Group Code

**DESCRIPTION:** Claim adjustment group code used to categorize a payment adjustment for a claim or claim line. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

**SHORT NAME:** LINE_ADJUST_GRP_CD

**LONG NAME:** LINE_ADJUST_GRP_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**
- CO = Contractual obligation
- OA = Other adjustment
- PR = Patient responsibility

**COMMENT:** This code set is an external code set maintained by X12 ([www.x12.org/codes](http://www.x12.org/codes)). This field is not populated prior to 2021.
**LINE_ADJUST_RSN_CD**

**LABEL:** Line Adjustment Reason Code

**DESCRIPTION:** Claim adjustment reason code used to describe why a claim or claim line was paid differently than billed. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

**SHORT NAME:** LINE_ADJUST_RSN_CD

**LONG NAME:** LINE_ADJUST_RSN_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** This is not a comprehensive list of values; refer to website below for current values and descriptions:

- 132 = Prearranged demonstration project adjustment

**COMMENT:** This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.
**LINE_ALOWD_CHRG_AMT**

**LABEL:** Line Allowed Charge Amount

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

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

**SHORT NAME:** LALOWCHG

**LONG NAME:** LINE_ALOWD_CHRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

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

LABEL: Line Payment Amount to Beneficiary

DESCRIPTION: The payment (reimbursement) made to the beneficiary related to the line-item service on the non-institutional claim.

SHORT NAME: LBENPMT

LONG NAME: LINE_BENE_PMT_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —
**LINE_BENE_PRMRY_PYR_CD**

**LABEL:** Line Primary Payer Code (if not Medicare)

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

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

**SHORT NAME:** LPRPAYCD

**LONG NAME:** LINE_BENE_PRMRY_PYR_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH, VA, DOL, SSA

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

Null/missing= Medicare is primary payer

**COMMENT:** Values C, M, N, and Null/missing indicate Medicare is primary payer.
**LINE_BENE_PRMRY_PYR_PD_AMT**

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

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

**SHORT NAME:** LPRPDAMT

**LONG NAME:** LINE_BENE_PRMRY_PYR_PD_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** —
**LINE_BENE_PTB_DDCTBL_AMT**

**LABEL:** Line Beneficiary Part B Deductible Amount

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

**SHORT NAME:** LDEDAMT

**LONG NAME:** LINE_BENE_PTB_DDCTBL_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**LINE_CMS_TYPE_SRVC_CD**

**LABEL:** Line CMS Type Service Code

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

**SHORT NAME:** TYPSRVC

**LONG NAME:** LINE_CMS_TYPE_SRVC_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

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

**COMMENT:** —
LINE_COINSRNC_AMT

LABEL: Line Beneficiary Coinsurance Amount

DESCRIPTION: The beneficiary coinsurance liability amount for this line-item service on the non-institutional claim. This variable is the beneficiary’s liability for coinsurance for the service on the line-item record. Beneficiaries only face coinsurance once they have satisfied Part B’s annual deductible, which applies to both institutional (e.g., Hospital outpatient) and non-institutional (e.g., Carrier and DME) services. For most Part B services, coinsurance equals 20 percent of the allowed amount.

SHORT NAME: COINAMT

LONG NAME: LINE_COINSRNC_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference the list of MLN publications at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html).

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LINE_DME_PRCHS_PRICE_AMT

LABEL: Line DME Purchase Price Amount

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

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

SHORT NAME: DME_PURC

LONG NAME: LINE_DME_PRCHS_PRICE_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —
**LINE_HCT_HGB_RSLT_NUM**

**LABEL:** Hematocrit/Hemoglobin Test Results

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

**SHORT NAME:** HCTHGBRS

**LONG NAME:** LINE_HCT_HGB_RSLT_NUM

**TYPE:** NUM

**LENGTH:** 4

**SOURCE:** NCH

**VALUES:** —

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

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

LABEL: Hematocrit/Hemoglobin Test Type Code

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

SHORT NAME: HCTHGBTP

LONG NAME: LINE_HCT_HGB_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: R1 = Hemoglobin Test
        R2 = Hematocrit Test

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

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

**LABEL:** Line Diagnosis Code

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

**SHORT NAME:** LINE_ICD_DGNS_CD

**LONG NAME:** LINE_ICD_DGNS_CD

**TYPE:** CHAR

**LENGTH:** 7

**SOURCE:** NCH

**VALUES:** —

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

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

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

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

SHORT NAME: LINE_ICD_DGNS_VRSN_CD

LONG NAME: LINE_ICD_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

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

**LABEL:** Line Last Expense Date

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

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

**SHORT NAME:** EXPNSDT2

**LONG NAME:** LINE_LAST_EXPNS_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —

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**LINE_NCH_PMT_AMT**

**LABEL:** Line NCH Medicare Payment Amount

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

**SHORT NAME:** LINEPMT

**LONG NAME:** LINE_NCH_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**LINE_NDC_CD**

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

**DESCRIPTION:** On the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs. This line-item field was added as a placeholder on the Carrier claim.

**SHORT NAME:** LNNDCCD

**LONG NAME:** LINE_NDC_CD

**TYPE:** CHAR

**LENGTH:** 11

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**LINE_NUM**

**LABEL:** Claim Line Number

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

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

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

**SHORT NAME:** LINE_NUM

**LONG NAME:** LINE_NUM

**TYPE:** NUM

**LENGTH:** 13

**SOURCE:** CCW

**VALUES:** —

**COMMENT:** —
**LABEL:** Line Other Applied Amount

**DESCRIPTION:** The field used to identify amounts that were used to adjust the amount payable when processing the line item.

**SHORT NAME:**
- LINE_OTHR_APLD_AMT1
- LINE_OTHR_APLD_AMT2
- LINE_OTHR_APLD_AMT3
- LINE_OTHR_APLD_AMT4
- LINE_OTHR_APLD_AMT5
- LINE_OTHR_APLD_AMT6
- LINE_OTHR_APLD_AMT7

**LONG NAME:**
- LINE_OTHR_APLD_AMT1
- LINE_OTHR_APLD_AMT2
- LINE_OTHR_APLD_AMT3
- LINE_OTHR_APLD_AMT4
- LINE_OTHR_APLD_AMT5
- LINE_OTHR_APLD_AMT6
- LINE_OTHR_APLD_AMT7

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Reference the associated line other applied indicator code in the LINE_OTHR_APLD_IND_CD(#) field. There are up to seven of these line applied amount fields (LINE_OTHR_APLD_AMT1–LINE_OTHR_APLD_AMT7).
LINE_OTHR_APLD_IND_CD1
LINE_OTHR_APLD_IND_CD2
LINE_OTHR_APLD_IND_CD3
LINE_OTHR_APLD_IND_CD4
LINE_OTHR_APLD_IND_CD5
LINE_OTHR_APLD_IND_CD6
LINE_OTHR_APLD_IND_CD7

LABEL: Line Other Applied Indicator Code

DESCRIPTION: The code used to identify the reason the claim payment amount was adjusted during claims processing.

SHORT NAME:

<table>
<thead>
<tr>
<th>SHORT NAME</th>
<th>LINE_OTHR_APLD_IND_CD1</th>
<th>LINE_OTHR_APLD_IND_CD2</th>
<th>LINE_OTHR_APLD_IND_CD3</th>
<th>LINE_OTHR_APLD_IND_CD4</th>
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<th>LINE_OTHR_APLD_IND_CD6</th>
<th>LINE_OTHR_APLD_IND_CD7</th>
</tr>
</thead>
</table>

LONG NAME:

<table>
<thead>
<tr>
<th>LONG NAME</th>
<th>LINE_OTHR_APLD_IND_CD1</th>
<th>LINE_OTHR_APLD_IND_CD2</th>
<th>LINE_OTHR_APLD_IND_CD3</th>
<th>LINE_OTHR_APLD_IND_CD4</th>
<th>LINE_OTHR_APLD_IND_CD5</th>
<th>LINE_OTHR_APLD_IND_CD6</th>
<th>LINE_OTHR_APLD_IND_CD7</th>
</tr>
</thead>
</table>

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:

<table>
<thead>
<tr>
<th>VALUE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Interest addition</td>
</tr>
<tr>
<td>C</td>
<td>Positive rounding adjustment (due to line-item distribution from total claim reimbursement amount)</td>
</tr>
<tr>
<td>D</td>
<td>Negative rounding adjustment (due to line-item distribution from total claim reimbursement amount)</td>
</tr>
<tr>
<td>E</td>
<td>Primary Payer allowed charge</td>
</tr>
<tr>
<td>F</td>
<td>Payment Reduction (Good cause or Late Billing)</td>
</tr>
<tr>
<td>G</td>
<td>Payment Reduction (PMDP Demonstration Reduction)</td>
</tr>
<tr>
<td>H</td>
<td>Payment Reduction (Sequestration Reduction)</td>
</tr>
<tr>
<td>I</td>
<td>Payment Reduction (ePrescribing Negative Adjustment)</td>
</tr>
<tr>
<td>J</td>
<td>ACO Payment Adjustment Amount (Pioneer reduction) — the amount that would have been paid if not for the Pioneer reduction — eff. 1/2014</td>
</tr>
<tr>
<td>K</td>
<td>Payment Reduction (ASC Quality Reporting Payment Reduction) — eff. 1/2014</td>
</tr>
</tbody>
</table>
L = ACO Payment Adjustment Amount (Pioneer reduction) — the actual amount of the Pioneer reduction — eff. 1/2014
M = Payment Reduction (Physician Quality Reporting System [PQRS] Negative Payment Adjustment) — eff. 1/2015
N = None (no amount to apply)
O = Negative or Positive Adjustment (Value Based Modifier [VBM] for reduction) — eff. 1/2015
P = Value Based Payment Modifier (VBM) Positive Payment Adjustment — eff. 1/2015
Q = Electronic Health Record (EHR) Negative Payment Adjustment — eff. 1/2015
R = Appropriate/Allowable Co-insurance (4/2023) previous value - Part B Drug Payment Model (retired)
S = Prior Authorization Reduction — eff. 10/2016
T = Comprehensive Primary Care Plus (CPC+) Payment Adjustment — eff. 4/2017
U = Maryland Primary Care Program (MDPCP) Adjustment — eff. 1/2019
V = Positive Amount for Quality Payment Program (QPP) payment adjustment — eff. 1/2019
W = Negative Amount for Quality Payment Program (QPP) payment adjustment — eff. 1/2019
X = Emergency Triage, Treat, and Transport (ET3) Model Payment — to indicate the amount by which each line was adjusted for the 15% bonus payment. — eff. 1/2020
Y = Oncology Care Model Plus (OCM+) Population Based Payment Claims Reductions — eff. 1/2020
A2 = Flat Visit Reduction Amount (PCF Model)
A3 = Flat Visit Fee Increased Amount (PCF Model)
A4 = KCF Model Reduction Amount
A5 = CKCC Model Reduction Amount
A6 = Performance Payment Adjustment (PPA) Addition (eff. 1/2022)
A7 = Performance Payment Adjustment (PPA) Reduction (eff. 1/2022)
A8 = Performance Based Adjustment (PBA) Addition (eff. 4/2022)
A9 = Performance Based Adjustment (PBA) Reduction (eff. 4/2022)
B1 = PTA/OTA 15% reduction for Therapy (eff.1/2022)
B2 = Co-Insurance Reduction Amount (eff. 1/2023)
B3 = Monthly Enhanced Oncology Services (MEOS) Positive Payment Adjustment (eff. 4/2023)

COMMENT:  Starting in January 2021 with NCH version L, this field was changed from 1 character to 2.
Reference the associated amounts in the LINE_OTHR_APLD_AMT(#) field.
There are up to 7 of these line applied indicator fields (LINE_OTHR_APLD_IND_CD1–LINE_OTHR_APLD_IND_CD7).
**LINE_PLACE_OF_SRVC_CD**

**LABEL:** Line Place of Service Code

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

**SHORT NAME:** PLCSRVC

**LONG NAME:** LINE_PLACE_OF_SRVC_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

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. (Eff. 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. (This code is available for use eff. January 1, 2013 but no later than May 1, 2013)

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. (Eff. 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 to sick or injured persons who do not require hospitalization or institutionalization.

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. (eff. 10/1/2003)

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 (eff. 1/2020)
59 = Unassigned. N/A
60 = Mass Immunization Center. A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61 = Comprehensive Inpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62 = Comprehensive outpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 = Unassigned. N/A
64 = Unassigned. N/A
65 = End-Stage Renal Disease Treatment Facility. A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66–70 = Unassigned. N/A
71 = Public Health Clinic. A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72 = Rural Health Clinic. A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73–80 = Unassigned. N/A
81 = Independent Laboratory. A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82–98 = Unassigned. N/A
99 = Other Place of Service. Other place of service not identified above.

COMMENT:

—

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**LINE_PMT_80_100_CD**

**LABEL:** Line Payment 80%/100% Code

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

**SHORT NAME:** PMTINDSW

**LONG NAME:** LINE_PMT_80_100_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

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

**COMMENT:** —

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**LINE_PRCSG_IND_CD**

**LABEL:** Line Processing Indicator Code

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

**SHORT NAME:** PRCNGIND

**LONG NAME:** LINE_PRCSG_IND_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- A = Allowed
- B = Benefits exhausted
- C = Non-covered care
- D = Denied (from BMAD)
- G = MSP cost avoided — secondary claims investigation
- H = MSP cost avoided — self reports
- I = Invalid data
- J = MSP cost avoided — 411.25
- K = MSP cost avoided — insurer voluntary reporting
- L = CLIA
- M = Multiple submittal-duplicate line item
- N = Medically unnecessary
- O = Other
- P = Physician ownership denial
- Q = MSP cost avoided (contractor #88888) — voluntary agreement
- R = Reprocessed adjustments based on subsequent reprocessing of claim
- S = Secondary payer
- T = MSP cost avoided — IEQ contractor
- U = MSP cost avoided — HMO rate cell adjustment
- V = MSP cost avoided — litigation settlement
- X = MSP cost avoided — generic
- Y = MSP cost avoided — IRS/SSA data match project
- Z = Bundled test, no payment
- 00 = MSP cost avoided — COB contractor
- 12 = MSP cost avoided — BC/BS voluntary agreements
- 13 = MSP cost avoided — Office of Personnel Management
- 14 = MSP cost avoided — Workman’s Compensation (WC) Datamatch
- 15 = MSP cost avoided — Workman’s Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)
- 16 = MSP cost avoided — Liability Insurer VDSA (eff.4/2006)
- 17 = MSP cost avoided — No-Fault Insurer VDSA (eff.4/2006)
- 18 = MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (eff.4/2006)
- 21 = MSP cost avoided — MIR Group Health Plan (eff.1/2009)
22 = MSP cost avoided — MIR non-Group Health Plan (eff.1/2009)
25 = MSP cost avoided — Recovery Audit Contractor — California (eff.10/2005)
26 = MSP cost avoided — Recovery Audit Contractor — Florida (eff.10/2005)

Effective 4/1/2002, the Line Processing Indicator code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code.

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

!  MSP cost avoided — COB Contractor (‘00’ 2-byte code)
@  MSP cost avoided — BC/BS Voluntary Agreements (‘12’ 2-byte code)
#  MSP cost avoided — Office of Personnel Management (‘13’ 2-byte code)
$  MSP cost avoided — Workman’s Compensation (WC) Datamatch (‘14’ 2-byte code)
*  MSP cost avoided — Workman’s Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (‘15’ 2-byte code) (eff. 4/2006)
(  MSP cost avoided — Liability Insurer VDSA (‘16’ 2-byte code) (eff. 4/2006)
)  MSP cost avoided — No-Fault Insurer VDSA (‘17’ 2-byte code) (eff. 4/2006)
+  MSP cost avoided — Pharmacy Benefit Manager Data Sharing Agreement (‘18’ 2-byte code) (eff. 4/2006)
<  MSP cost avoided — MIR Group Health Plan (‘21’ 2-byte code) (eff. 1/2009)
>  MSP cost avoided — MIR non-Group Health Plan (‘22’ 2-byte code) (eff. 1/2009)
%  MSP cost avoided — Recovery Audit Contractor — California (‘25’ 2-byte code) (eff. 10/2005)
&  MSP cost avoided — Recovery Audit Contractor — Florida (‘26’ 2-byte code) (eff. 10/2005)

COMMENT: —

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**LINE_PRMRY_ALOWD_CHRG_AMT**

**LABEL:** Line Primary Payer Allowed Charge Amount  

**DESCRIPTION:** The primary payer allowed charge amount for the line-item service on the non-institutional claim. If there is a primary payer other than Medicare, there may be an allowed payment for the provider; if so, this field is populated.

**SHORT NAME:** PRPYALOW  

**LONG NAME:** LINE_PRMRY_ALOWD_CHRG_AMT  

**TYPE:** NUM  

**LENGTH:** 12  

**SOURCE:** NCH  

**VALUES:** —  

**COMMENT:** —
**LINE_PRVDR_PMT_AMT**

**LABEL:** Line Provider Payment Amount

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

**SHORT NAME:** LPRVPMT

**LONG NAME:** LINE_PRVDR_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** —

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**LINE_PRVDR_VLDTN_TYPE_CD**

**LABEL:** Line Provider Validation Type Code

**DESCRIPTION:** Line Provider Validation Type Code for Carrier claim lines

**SHORT NAME:** LINE_PRVDR_VLDTN_TYPE_CD

**LONG NAME:** LINE_PRVDR_VLDTN_TYPE_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**
- RP = Rendering Provider
- OP = Operating Physician
- CP = Ordering/Referring Physician
- AP = Attending Physician
- FA = Facility

**COMMENT:** The purpose of the Provider Validation Type field on the claim is to inform Common Working File (CWF) to perform an edit check to ensure that the provider that was submitted on the Prior Authorization (PA) request is the same provider on the claim.

This field was new in April 2019.

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**LINE_RA_RMRK_CD**

**LABEL:** Line Remittance Advice Remark Code

**DESCRIPTION:** Claim remittance advice remark code used to provide an additional explanation for an adjustment already described by a claim adjustment reason code (CARC) for a claim or claim line. It is also used to communicate information about remittance processing. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

**SHORT NAME:** LINE_RA_RMRK_CD

**LONG NAME:** LINE_RA_RMRK_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** This is not a comprehensive list of values; refer to website below for current values and descriptions:
- N83 = No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

**COMMENT:** This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.
**LINE_RP_IND_CD**

**LABEL:** Line Representative Payee (RP) Indicator Code

**DESCRIPTION:** Line Representative Payee (RP) Indicator Code

**SHORT NAME:** LINE_RP_IND_CD

**LONG NAME:** LINE_RP_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** R = bypass representative payee

**COMMENT:** This field is used to designate by-passing of the prior authorization processing for claims with a representative payee when an 'R' is present in the field.

Data will not start coming in until April 2016.
**LINE_RR_BRD_EXCLSN_IND_SW**

**LABEL:**  
Line Railroad Board Exclusion Indicator Switch

**DESCRIPTION:**  
This field indicates whether Railroad Board (RRB) beneficiary durable medical equipment (DME) claim line should be excluded from Prior Authorization (PA) processing.

**SHORT NAME:**  
LINE_RR_BRD_EXCLSN_IND_SW

**LONG NAME:**  
LINE_RR_BRD_EXCLSN_IND_SW

**TYPE:**  
CHAR

**LENGTH:**  
1

**SOURCE:**  
NCH

**VALUES:**  
Y = Yes (exclude RRB beneficiary from PA)  
Null/missing = Subject RRB beneficiary services to prior authorization

**COMMENT:**  
This field informs the SSMs and CWF if the RRB beneficiary claim should either be included or excluded from Prior Authorization (PA) processing. (e.g., if the field is valued “Y”, and it is RRB beneficiary claim, it will be excluded from PA processing).

This field was new in April 2019.
**LINE_RSDL_PYMT_IND_CD**

**LABEL:** Line Residual Payment Indicator Code

**DESCRIPTION:** This field is used by CWF claims processing for the purpose of bypassing its normal MSP editing that would otherwise apply for ongoing responsibility for medicals (ORM) or worker's compensation Medicare Set-Aside Arrangements (WCMSA). Normally, CWF does not allow a secondary payment on MSP involving ORM or WCMSA, so the residual payment indicator is used to allow CWF to make an exception to its normal routine.

**SHORT NAME:** LINE_RSDL_PYMT_IND_CD

**LONG NAME:** LINE_RSDL_PYMT_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** X = Residual Payment

**COMMENT:** This field was new in April 2016 and is null/missing for all previous years.
LINE_SBMTD_CHRG_AMT

LABEL: Line Submitted Charge Amount

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

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

SHORT NAME: LSBMTC HG

LONG NAME: LINE_SBMTD_CHRG_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

COMMENT: —
**LINE_SERVICE_DEDUCTIBLE**

**LABEL:** Line Service Deductible Indicator Switch

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

**SHORT NAME:** DED_SW

**LONG NAME:** LINE_SERVICE_DEDUCTIBLE

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- 0 = Service Subject to Deductible
- 1 = Service Not Subject to Deductible

**COMMENT:** —
**LINE_SRVC_CNT**

**LABEL:** Line Service Count

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

**SHORT NAME:** SRVC_CNT

**LONG NAME:** LINE_SRVC_CNT

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** This field may have decimals (it is formatted as SAS length 11.3).
<table>
<thead>
<tr>
<th><strong>LINE_VLNTRY_SRVC_IND_CD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong></td>
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<td><strong>LONG NAME:</strong></td>
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<td><strong>TYPE:</strong></td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
</tr>
</tbody>
</table>
| **VALUES:** | V = A voluntary procedure code  
Null/missing = A required procedure code |
| **COMMENT:** | This field was new in January 2021. |

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**LTCH_DSCHRG_PYMT_ADJSTMT_AMT**

**LABEL:** LTCH Discharge Payment Adjustment Amount

**DESCRIPTION:** Identifies the amount of a long-term care hospital discharge payment percentage adjustment that will be applied to the payment rate for failure to maintain the required discharge payment percentage.

**SHORT NAME:** LTCH_DSCHRG_PYMT_ADJSTMT_AMT

**LONG NAME:** LTCH_DSCHRG_PYMT_ADJSTMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** The adjustment has been applied to the Claim Payment Amount (CLM_PMT_AMT).

This field is new with the NCH Version L layout; it is not populated before January 2021.
MS_DRG_GRPR_VRSN_CD

LABEL: MS-DRG Grouper Version Code

DESCRIPTION: This field displays the Medicare-Severity Diagnosis Related Group (MS-DRG) Grouper Version for the inpatient or skilled nursing facility (SNF) claim.

SHORT NAME: MS_DRG_GRPR_VRSN_CD

LONG NAME: MS_DRG_GRPR_VRSN_CD

TYPE: CHAR

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated prior to 2021. GROUPER is the software that determines the DRG from data elements reported by the hospital.

Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment.

Nonpayment claims (zero reimbursement) may not have a DRG present.

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**NCH_ACTV_OR_CVRD_LVL_CARE_THRU**

**LABEL:** NCH Active or Covered Level Care Thru Date

**DESCRIPTION:** The date on a claim for which the covered level of care ended in a general hospital or the active care ended in a psychiatric/tuberculosis hospital.

**SHORT NAME:** CARETHRU

**LONG NAME:** NCH_ACTV_OR_CVRD_LVL_CARE_THRU

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** —

**COMMENT:** This variable is derived, using the occurrence code (variable called CLM_RLT_OCRNC_CD), when the value is 22. When this code value is present the date is populated using the CLM_RLT_OCRNC_DT.
NCH_BENE_BLOOD_DDCTBL_LBLTY_AM

LABEL:  NCH Beneficiary Blood Deductible Liability Amount

DESCRIPTION:  The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.

A blood deductible amount applies to the first three pints of blood (or equivalent units; applies only to whole blood or packed red cells — not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

SHORT NAME:  BLDDEDAM

LONG NAME:  NCH_BENE_BLOOD_DDCTBL_LBLTY_AM

TYPE:  NUM

LENGTH:  12

SOURCE:  NCH QA PROCESS

VALUES:  XXX.XX

COMMENT:  Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits," which explains the blood deductible.

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**NCH_BENE_DSCHRG_DT**

**LABEL:** NCH Beneficiary Discharge Date

**DESCRIPTION:** On an inpatient or home health claim, the date the beneficiary was discharged from the facility, or died.

Date matches the "thru" date on the claim (CLM_THRU_DT) unless the beneficiary is still a patient (i.e., this field is not populated if discharge status code [PTNT_DSCHRG_STUS_CD]= 30 [still a patient]). When there is a discharge date, the PTNT_DSCHRG_STUS_CD indicates the final disposition of the patient after discharge.

**SHORT NAME:** DSCHRGDT

**LONG NAME:** NCH_BENE_DSCHRG_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** —

**COMMENT:** —
**NCH_BENE_IP_DDCTBL_AMT**

**LABEL:** NCH Beneficiary Inpatient (or other Part A) Deductible Amount

**DESCRIPTION:** The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.

Under Part A, the deductible applies only to inpatient hospital care (whether in an acute care facility, inpatient psychiatric facility [IPF], inpatient rehabilitation facility [IRF], or long-term care hospital [LTCH]) and is charged only at the beginning of each benefit period, which is similar to an episode of illness.

This variable is null/missing for skilled nursing facility (SNF), home health, and hospice claims.

**SHORT NAME:** DED_AMT

**LONG NAME:** NCH_BENE_IP_DDCTBL_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website.
**NCH_BENE_MDCR_BNFTS_EXHTD_DT_I**

**LABEL:** NCH Beneficiary Medicare Benefits Exhausted Date

**DESCRIPTION:** The last date for which the beneficiary has Medicare coverage.

This is completed only where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim.

**SHORT NAME:** EXHST_DT

**LONG NAME:** NCH_BENE_MDCR_BNFTS_EXHTD_DT_I

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA process

**VALUES:** —

**COMMENT:** Derived from: CLM_RLT_OCRNC_CD and CLM_RLT_OCRNC_DT

Derivation rules: Based on the presence of occurrence code A3, B3, or C3 move the related occurrence date to NCH_MDCR_BNFT_EXHST_DT.
**NCH_BENE_PTA_COINSRNC_LBLTY_AM**

**LABEL:** NCH Beneficiary Part A Coinsurance Liability Amount

**DESCRIPTION:** The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim.

Under Part A, beneficiaries pay coinsurance starting with the 61st day of an inpatient hospital stay (one daily amount for days 61–90, and a higher daily amount for any days after that, which count towards a beneficiary’s 60 lifetime reserve days) or the 21st day of a skilled nursing facility (SNF) stay (a daily amount for days 21–100, after which SNF coverage ends).

This variable is null/missing for home health and hospice claims.

**SHORT NAME:** COIN_AMT

**LONG NAME:** NCH_BENE_PTA_COINSRNC_LBLTY_AM

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website.

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**NCH_BENE_PTB_COINSRNC_AMT**

**LABEL:** NCH Beneficiary Part B Coinsurance Amount

**DESCRIPTION:** The amount of money for which the intermediary has determined that the beneficiary is liable for Part B coinsurance on the institutional claim.

**SHORT NAME:** PTB_COIN

**LONG NAME:** NCH_BENE_PTB_COINSRNC_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA PROCESS

**VALUES:** XXX.XX

**COMMENT:** Derivation Rules: If value codes (variable called CLM_VAL_CD) = A2, B2, or C2, then the related value amount (variable called CLM_VAL_AMT) is output to this field.

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**NCH_BENE_PTB_DDCTBL_AMT**

**LABEL:** NCH Beneficiary Part B Deductible Amount

**DESCRIPTION:** The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B cash deductible on the claim.

**SHORT NAME:** PTB_DED

**LONG NAME:** NCH_BENE_PTB_DDCTBL_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA PROCESS

**VALUES:** XXX.XX

**COMMENT:** Derivation Rules: If value codes (variable called CLM_VAL_CD) = A1, B1, or C1, then the related value amount (variable called CLM_VAL_AMT) is output to this field.
**NCH_BLOOD_PNTS_FRNSHD_QTY**

**LABEL:** NCH Blood Pints Furnished Quantity

**DESCRIPTION:** Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).

**SHORT NAME:** BLDFRNSH

**LONG NAME:** NCH_BLOOD_PNTS_FRNSHD_QTY

**TYPE:** NUM

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**NCH_CARR_CLM_ALOWD_AMT**

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

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

**SHORT NAME:**  ALOWCHRG

**LONG NAME:**  NCH_CARR_CLM_ALOWD_AMT

**TYPE:**  NUM

**LENGTH:**  12

**SOURCE:**  NCH QA Process

**VALUES:**  XXX.XX

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

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/)).

**NCH_CARR_CLM_SBMTD_CHRG_AMT**

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

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

**SHORT NAME:** SBMTCHRG

**LONG NAME:** NCH_CARR_CLM_SBMTD_CHRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

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

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/)).

**NCH_CLM_BENE_PMT_AMT**

**LABEL:** NCH Claim Payment Amount to Beneficiary

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

**SHORT NAME:** BENE_PMT

**LONG NAME:** NCH_CLM_BENE_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** This variable is populated if, for example, a beneficiary pays for a service that should have been Medicare-covered.

The beneficiary can be refunded the payment.

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

Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (reference: [https://www.medpac.gov/document-type/payment-basic/](https://www.medpac.gov/document-type/payment-basic/)).


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**NCH_CLM_PRVDR_PMT_AMT**

**LABEL:** NCH Claim Provider Payment Amount

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

**SHORT NAME:** PROV_PMT

**LONG NAME:** NCH_CLM_PRVDR_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX


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**NCH_CLM_TYPE_CD**

**LABEL:** NCH Claim Type Code

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

**SHORT NAME:** CLM_TYPE

**LONG NAME:** NCH_CLM_TYPE_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**
- 10 = Home health agency (HHA) claim
- 20 = Non swing bed skilled nursing facility (SNF) claim
- 30 = Swing bed SNF claim
- 40 = Hospital outpatient claim
- 50 = Hospice claim
- 60 = Inpatient claim
- 71 = Local carrier non-durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claim
- 72 = Local carrier DMEPOS claim
- 81 = Durable medical equipment regional carrier (DMERC); non-DMEPOS claim
- 82 = DMERC; DMEPOS claim

**COMMENT:** This variable may not always indicate the type of service performed; for example, when the claim type code = 60 (inpatient), the services may actually be for post-acute care. Additional information regarding the type of service on the claim can be found in a CCW Technical Guidance document entitled: "Getting Started with Medicare data".

Note that there is a data issue with the incorrect assignment of National Claims History (NCH) claim type codes for 37,962 Part B Carrier and DMERC (claim type codes 71,72,81,82) claims processed on 01/27/23 (i.e., the NCH_WKLY_PROC_DT). For nearly all of the affected claims, the NCH_CLM_TYPE_CD was incorrectly assigned an 81 instead of 82; there are also 7 of the total impacted claims where the NCH_CLM_TYPE_CD was incorrectly assigned 71 instead of 72.
**NCH_DRG_OUTLIER_APRVD_PMT_AMT**

**LABEL:** NCH DRG Outlier Approved Payment Amount

**DESCRIPTION:** On an institutional claim, the additional payment amount approved by the Quality Improvement Organization due to an outlier situation for a beneficiary's stay under the prospective payment system (PPS), which has been classified into a specific diagnosis related group (DRG).

This variable will typically include the total outlier payment amount, if any, for the claim.

**SHORT NAME:** OUTLRPMT

**LONG NAME:** NCH_DRG_OUTLIER_APRVD_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** —

**COMMENT:** —
**NCH_IP_NCVRD_CHRG_AMT**

**LABEL:** NCH Inpatient (or other Part A) Non-covered Charge Amount

**DESCRIPTION:** The non-covered charges for all accommodations and services, reported on an inpatient claim (used for internal NCHMQA editing purposes).

**SHORT NAME:** NCCHGAMT

**LONG NAME:** NCH_IP_NCVRD_CHRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** DERIVED FROM:

- REV_CNTR_CD
- REV_CNTR_NCVR_CHRG_AMT

Derivation Rules: Based on the presence of revenue center code equal to 0001, move the related non-covered charge amount to NCH_IP_NCOV_CHRG_AMT.
<table>
<thead>
<tr>
<th><strong>NCH_IP_TOT_DDCTN_AMT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong> NCH Inpatient (or other Part A) Total Deductible/Coinsurance Amount</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> The total of all Part A and blood deductibles and coinsurance amounts on the claim.</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong> TDEDAMT</td>
</tr>
<tr>
<td><strong>LONG NAME:</strong> NCH_IP_TOT_DDCTN_AMT</td>
</tr>
<tr>
<td><strong>TYPE:</strong> NUM</td>
</tr>
<tr>
<td><strong>LENGTH:</strong> 12</td>
</tr>
<tr>
<td><strong>SOURCE:</strong> NCH QA Process</td>
</tr>
<tr>
<td><strong>VALUES:</strong> XXX.XX</td>
</tr>
<tr>
<td><strong>COMMENT:</strong> Derivation Rules: Accumulate the value amounts (from field called CLM_VAL_AMT) associated with value codes (CLM_VAL_CD) equal to 06, 08 thru 11 and A1, B1, or C1 and output to this field.</td>
</tr>
</tbody>
</table>
**NCH_NEAR_LINE_REC_IDENT_CD**

**LABEL:** NCH Near Line Record Identification Code (RIC)

**DESCRIPTION:** A code defining the type of claim record being processed.

**SHORT NAME:** RIC_CD

**LONG NAME:** NCH_NEAR_LINE_REC_IDENT_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- M = Part B DMEPOS claim record (processed by DME regional carrier)
- O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
- U = Both Part A and B institutional home health agency (HHA) claim records
- V = Part A institutional claim record (inpatient [IP], skilled nursing facility [SNF], hospice [HOS], or home health agency [HHA])
- W = Part B institutional claim record (outpatient [HOP], HHA)

**COMMENT:** —
NCH_PRMRY_PYR_CLM_PD_AMT

LABEL: NCH Primary Payer (if not Medicare) Claim Paid Amount

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

SHORT NAME: PRPAYAMT

LONG NAME: NCH_PRMRY_PYR_CLM_PD_AMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Derivation Rules: It is calculated as the sum of the line-level primary payer amounts.
**NCH_PRMRY_PYR_CD**

**LABEL:** NCH Primary Payer Code (if not Medicare)

**DESCRIPTION:** The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary’s health insurance bills.

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

**SHORT NAME:** PRPAY_CD

**LONG NAME:** NCH_PRMRY_PYR_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

A = Employer group health plan (EGHP) insurance for an aged beneficiary
B = EGHP insurance for an end-stage renal disease (ESRD) beneficiary
C = Conditional payment by Medicare; future reimbursement from the Public Health Service (PHS) expected
D = No fault automobile insurance
E = Worker’s compensation (WC)
F = Public Health Service (PHS) or other federal agency (other than VA)
G = Working disabled beneficiary under age 65 with a local government health plan (LGHP)
H = Black lung (BL) program
I = Department of Veteran's Affairs
L = Any liability insurance
M = Override EGHP — Medicare is primary payer
N = Override non-EGHP — Medicare is primary payer
Blank /missing = No other primary payer

**COMMENT:** —
**NCH_PROFNL_CMPNT_CHRG_AMT**

**LABEL:** Professional Component Charge Amount

**DESCRIPTION:** This field is the amount of physician and other professional charges covered under Medicare Part B.

**SHORT NAME:** PCCHGAMT

**LONG NAME:** NCH_PROFNL_CMPNT_CHRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH QA Process

**VALUES:** XXX.XX

**COMMENT:** This variable is not populated for home health or hospice claims.

This field is used for CMS editing purposes and other internal processes (e.g., if computing interim payments, then these charges are deducted).

The source of information for this field for institutional claims is the CLM_VAL_AMT (when the code = 04 or 05, it indicates a professional component charge amount).

For outpatient claims, this information is from the revenue center codes (when the code=096*, 097* or 098*, then the REV_CNTR_TOT_CHRG_AMT indicates a professional component charge amount).
**NCH_PTNT_STUS_IND_CD**

**LABEL:**  NCH Patient Status Indicator Code

**DESCRIPTION:** This variable is a recoded version of the discharge status code (variable called PTNT_DSCHRG_STUS_CD).

**SHORT NAME:**  PTNTSTUS

**LONG NAME:**  NCH_PTNT_STUS_IND_CD

**TYPE:**  CHAR

**LENGTH:**  1

**SOURCE:** NCH QA Process

**VALUES:**
- A = Discharged
- B = Died
- C = Still a patient

**COMMENT:** —
**NCH_QLFYD_STAY_FROM_DT**

**LABEL:** NCH Qualified Stay From Date

**DESCRIPTION:** The beginning date of the beneficiary's qualifying Medicare stay.

For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization of benefits.

For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A' (transfer from critical access hospital), or at least three days in a row if the source of admission is other than 'A'.

**SHORT NAME:** QLFYFROM

**LONG NAME:** NCH_QLFYD_STAY_FROM_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** —

**COMMENT:** Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_OCRNC_SPAN_CD) 70. When this code value is present the date is populated using the CLM_OCRNC_SPAN_FROM_DT.

[^ Back to TOC ^]
NCH_QLFYD_STAY_THRU_DT

LABEL: NCH Qualified Stay Through Date

DESCRIPTION: The ending date of the beneficiary's qualifying Medicare stay.

For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization of benefits.

For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A' (transfer from critical access hospital), or at least three days in a row if the source of admission is other than 'A'.

SHORT NAME: QLFYTHRU

LONG NAME: NCH_QLFYD_STAY_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH QA Process

VALUES: —

COMMENT: Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_OCRNC_SPAN_CD) 70. When this code value is present the date is populated using the CLM_OCRNC_SPAN_THRU_DT.
**NCH_VRFD_NCVRD_STAY_FROM_DT**

**LABEL:** NCH Verified Non-covered Stay From Date

**DESCRIPTION:** The beginning date of the beneficiary's Non-covered stay.

Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive.

For some beneficiaries, all days in one of these settings may not be covered by Medicare.

**SHORT NAME:** NCOVFROM

**LONG NAME:** NCH_VRFD_NCVRD_STAY_FROM_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** —

**COMMENT:** Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM_SPAN_FROM_DT.
**NCH_VRFD_NCVRD_STAY_THRU_DT**

**LABEL:** NCH Verified Non-covered Stay Through Date

**DESCRIPTION:** The ending date of the beneficiary's non-covered stay.

Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive. For some beneficiaries, all days in one of these settings may not be covered by Medicare.

**SHORT NAME:** NCOVTHRU

**LONG NAME:** NCH_VRFD_NCVRD_STAY_THRU_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH QA Process

**VALUES:** —

**COMMENT:** Derivation Rules: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM_SPAN_THRU_DT.
NCH_WKLY_PROC_DT

LABEL: NCH Weekly Claim Processing Date

DESCRIPTION: The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

SHORT NAME: WKLY_DT

LONG NAME: NCH_WKLY_PROC_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: —
### OP_PHYSN_NPI

**LABEL:** Claim Operating Physician NPI Number

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

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

**SHORT NAME:** OP_NPI

**LONG NAME:** OP_PHYSN_NPI

**TYPE:** CHAR

**LENGTH:** 10

**SOURCE:** NCH

**VALUES:** —

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

[^ Back to TOC ^]
**OP_PHYSN_SPCLTY_CD**

**LABEL:** Claim Operating Physician Specialty Code

**DESCRIPTION:** The code used to identify the CMS specialty code corresponding to the operating physician. The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physicians is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.

**SHORT NAME:** OP_PHYSN_SPCLTY_CD

**LONG NAME:** OP_PHYSN_SPCLTY_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Intervventional Pain Management (IPM) (eff. 4/1/2003)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative medicine
13 = Neurology
14 = Neurosurgery
15 = Speech/language pathologist in private practice
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports medicine
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive cardiac rehabilitation
32 = Anesthesiologist Assistant (eff. 4/1/2003 — previously grouped with Anesthesiologist Assistants (CRNA))
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry
42 = Certified nurse midwife
43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Independent Diagnostic Testing Facility (IDTF)</td>
</tr>
<tr>
<td>48</td>
<td>Podiatry</td>
</tr>
<tr>
<td>49</td>
<td>Ambulatory surgical center (formerly miscellaneous)</td>
</tr>
<tr>
<td>50</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>51</td>
<td>Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>52</td>
<td>Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>53</td>
<td>Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>54</td>
<td>Medical supply company for DMERC (and not included in 51–53)</td>
</tr>
<tr>
<td>55</td>
<td>Individual certified orthotic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>56</td>
<td>Individual certified prosthetic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>57</td>
<td>Individual certified prosthetic-orthotic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>58</td>
<td>Medical supply company with registered pharmacist</td>
</tr>
<tr>
<td>59</td>
<td>Ambulance service (private)</td>
</tr>
<tr>
<td>60</td>
<td>Public health or welfare agencies (federal, state, and local)</td>
</tr>
<tr>
<td>61</td>
<td>Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)</td>
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<tr>
<td>62</td>
<td>Psychologist (billing independently)</td>
</tr>
<tr>
<td>63</td>
<td>Portable X-ray supplier (billing independently)</td>
</tr>
<tr>
<td>64</td>
<td>Audiologist (billing independently)</td>
</tr>
<tr>
<td>65</td>
<td>Physical therapist in private practice</td>
</tr>
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<td>66</td>
<td>Rheumatology</td>
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<td>67</td>
<td>Occupational therapist in private practice</td>
</tr>
<tr>
<td>68</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>69</td>
<td>Clinical laboratory (billing independently)</td>
</tr>
<tr>
<td>70</td>
<td>Single or Multispecialty clinic or group practice (PA Group)</td>
</tr>
<tr>
<td>71</td>
<td>Registered Dietician/Nutrition Professional (eff. 1/1/2002)</td>
</tr>
<tr>
<td>72</td>
<td>Pain Management (eff. 1/1/2002)</td>
</tr>
<tr>
<td>73</td>
<td>Mass Immunization Roster Biller</td>
</tr>
<tr>
<td>74</td>
<td>Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF))</td>
</tr>
<tr>
<td>75</td>
<td>Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/1/2003))</td>
</tr>
<tr>
<td>76</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>77</td>
<td>Vascular surgery</td>
</tr>
<tr>
<td>78</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>79</td>
<td>Addiction medicine</td>
</tr>
<tr>
<td>80</td>
<td>Licensed clinical social worker</td>
</tr>
<tr>
<td>81</td>
<td>Critical care (intensivists)</td>
</tr>
<tr>
<td>82</td>
<td>Hematology</td>
</tr>
<tr>
<td>83</td>
<td>Hematology/oncology</td>
</tr>
<tr>
<td>84</td>
<td>Preventive medicine</td>
</tr>
<tr>
<td>85</td>
<td>Maxillofacial surgery</td>
</tr>
<tr>
<td>86</td>
<td>Neuropsychiatry</td>
</tr>
<tr>
<td>87</td>
<td>All other suppliers (e.g., drug stores)</td>
</tr>
<tr>
<td>88</td>
<td>Unknown provider</td>
</tr>
<tr>
<td>89</td>
<td>Certified clinical nurse specialist</td>
</tr>
<tr>
<td>90</td>
<td>Medical oncology</td>
</tr>
<tr>
<td>91</td>
<td>Surgical oncology</td>
</tr>
<tr>
<td>92</td>
<td>Radiation oncology</td>
</tr>
<tr>
<td>93</td>
<td>Emergency medicine</td>
</tr>
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<td>94</td>
<td>Interventional radiology</td>
</tr>
<tr>
<td>96</td>
<td>Optician</td>
</tr>
<tr>
<td>97</td>
<td>Physician assistant</td>
</tr>
<tr>
<td>98</td>
<td>Gynecological/oncology</td>
</tr>
<tr>
<td>99</td>
<td>Unknown physician specialty</td>
</tr>
</tbody>
</table>
A0 = Hospital (DMERCs only)
A1 = Skilled nursing facility (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/2007)
B2 = Pedorthic Personnel (eff. 10/2/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery (MDS) (eff. October 1, 2020)

COMMENT: —
**OP_PHYSN_UPIN**

**LABEL:** Claim Operating Physician UPIN Number

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

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

**SHORT NAME:** OP_UPIN

**LONG NAME:** OP_PHYSN_UPIN

**TYPE:** CHAR

**LENGTH:** 6

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**ORDRG_PHYSN_NPI**

**LABEL:**  Revenue Center Ordering Physician NPI

**DESCRIPTION:**  Effective with Version ‘L’ of the NCH layout, this line level field identifies the ordering physician’s National Provider Identifier (NPI).

**SHORT NAME:**  ORDRG_PHYSN_NPI

**LONG NAME:**  ORDRG_PHYSN_NPI

**TYPE:**  CHAR

**LENGTH:**  12

**SOURCE:**  NCH

**VALUES:**  —

**COMMENT:**  This field was new in January 2021.
**ORG_NPI_NUM**

**LABEL:** Organization (or group) NPI Number  

**DESCRIPTION:** The National Provider Identifier (NPI) of the organization or group practice.  

**SHORT NAME:** ORGNPINM  

**LONG NAME:** ORG_NPI_NUM  

**TYPE:** CHAR  

**LENGTH:** 10  

**SOURCE:** NCH  

**VALUES:** —  

**COMMENT:** On an institutional claim, this is the NPI number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.  

On the carrier claim, this is line-level information regarding the performing physician (Short Name = PRGRPNPI); it is the NPI of the group practice, where the performing physician is part of that group.
OT_PHYSN_NPI

LABEL: Claim Other Physician NPI Number

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

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

SHORT NAME: OT_NPI

LONG NAME: OT_PHYSN_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

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

^ Back to TOC ^
**OT_PHYSN_SPCLTY_CD**

**LABEL:** Claim Other Physician Specialty Code

**DESCRIPTION:** The code used to identify the CMS specialty code corresponding to the other physician.

**SHORT NAME:** OT_PHYSN_SPCLTY_CD

**LONG NAME:** OT_PHYSN_SPCLTY_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/2003)
- 10 = Gastroenterology
- 11 = Internal medicine
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- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech/language pathologist in private practice
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 23 = Sports medicine
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = Geriatric Psychiatry
- 28 = Colorectal surgery (formerly proctology)
- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation
- 32 = Anesthesiologist Assistant (eff. 4/1/2003 — previously grouped with Certified Registered Nurse Anesthetists (CRNA))
- 33 = Thoracic surgery
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- 40 = Hand surgery
- 41 = Optometry
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
- 47 = Independent Diagnostic Testing Facility (IDTF)
- 48 = Podiatry
- 49 = Ambulatory surgical center (formerly miscellaneous)
- 50 = Nurse practitioner
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<th>Code</th>
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<td>54</td>
<td>Medical supply company for DMERC (and not included in 51–53)</td>
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<td>Individual certified orthotic personnel certified by an accreditting organization</td>
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</tr>
<tr>
<td>72</td>
<td>Pain Management (eff. 1/1/2002)</td>
</tr>
<tr>
<td>73</td>
<td>Mass Immunization Roster Biller</td>
</tr>
<tr>
<td>74</td>
<td>Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF))</td>
</tr>
<tr>
<td>75</td>
<td>Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/1/2003))</td>
</tr>
<tr>
<td>76</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>77</td>
<td>Vascular surgery</td>
</tr>
<tr>
<td>78</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>79</td>
<td>Addiction medicine</td>
</tr>
<tr>
<td>80</td>
<td>Licensed clinical social worker</td>
</tr>
<tr>
<td>81</td>
<td>Critical care (intensivists)</td>
</tr>
<tr>
<td>82</td>
<td>Hematology</td>
</tr>
<tr>
<td>83</td>
<td>Hematology/oncology</td>
</tr>
<tr>
<td>84</td>
<td>Preventive medicine</td>
</tr>
<tr>
<td>85</td>
<td>Maxillofacial surgery</td>
</tr>
<tr>
<td>86</td>
<td>Neuropsychiatry</td>
</tr>
<tr>
<td>87</td>
<td>All other suppliers (e.g., drug stores)</td>
</tr>
<tr>
<td>88</td>
<td>Unknown provider</td>
</tr>
<tr>
<td>89</td>
<td>Certified clinical nurse specialist</td>
</tr>
<tr>
<td>90</td>
<td>Medical oncology</td>
</tr>
<tr>
<td>91</td>
<td>Surgical oncology</td>
</tr>
<tr>
<td>92</td>
<td>Radiation oncology</td>
</tr>
<tr>
<td>93</td>
<td>Emergency medicine</td>
</tr>
<tr>
<td>94</td>
<td>Interventional radiology</td>
</tr>
<tr>
<td>96</td>
<td>Optician</td>
</tr>
<tr>
<td>97</td>
<td>Physician assistant</td>
</tr>
<tr>
<td>98</td>
<td>Gynecological/oncology</td>
</tr>
<tr>
<td>99</td>
<td>Unknown physician specialty</td>
</tr>
<tr>
<td>A0</td>
<td>Hospital (DMERCs only)</td>
</tr>
<tr>
<td>A1</td>
<td>Skilled nursing facility (DMERCs only)</td>
</tr>
<tr>
<td>A2</td>
<td>Intermediate care nursing facility (DMERCs only)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>A3</td>
<td>Nursing facility, other (DMERCs only)</td>
</tr>
<tr>
<td>A4</td>
<td>Home health agency (DMERCs only)</td>
</tr>
<tr>
<td>A5</td>
<td>Pharmacy (DMERC)</td>
</tr>
<tr>
<td>A6</td>
<td>Medical supply company with respiratory therapist (DMERCs only)</td>
</tr>
<tr>
<td>A7</td>
<td>Department store (DMERC)</td>
</tr>
<tr>
<td>A8</td>
<td>Grocery store (DMERC)</td>
</tr>
<tr>
<td>A9</td>
<td>Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)</td>
</tr>
<tr>
<td>B1</td>
<td>Supplier of oxygen and/or oxygen related equipment (eff. 10/2/2007)</td>
</tr>
<tr>
<td>B2</td>
<td>Pedorthic Personnel (eff. 10/2/2007)</td>
</tr>
<tr>
<td>B3</td>
<td>Medical Supply Company with pedorthic personnel (eff. 10/2/2007)</td>
</tr>
<tr>
<td>B4</td>
<td>Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)</td>
</tr>
<tr>
<td>B5</td>
<td>Ocularist</td>
</tr>
<tr>
<td>C0</td>
<td>Sleep medicine</td>
</tr>
<tr>
<td>C1</td>
<td>Centralized flu</td>
</tr>
<tr>
<td>C2</td>
<td>Indirect payment procedure</td>
</tr>
<tr>
<td>C3</td>
<td>Interventional cardiology</td>
</tr>
<tr>
<td>C5</td>
<td>Dentist (eff. 7/2016)</td>
</tr>
<tr>
<td>C6</td>
<td>Hospitalist</td>
</tr>
<tr>
<td>C7</td>
<td>Advanced heart failure and transplant cardiology</td>
</tr>
<tr>
<td>C8</td>
<td>Medical toxicology</td>
</tr>
<tr>
<td>C9</td>
<td>Hematopoietic cell transplantation and cellular therapy</td>
</tr>
<tr>
<td>D3</td>
<td>Medical genetics and genomics</td>
</tr>
<tr>
<td>D4</td>
<td>Undersea and Hyperbaric Medicine</td>
</tr>
<tr>
<td>D5</td>
<td>Opioid Treatment Program (eff. 1/2020)</td>
</tr>
<tr>
<td>D7</td>
<td>Micrographic Dermatologic Surgery (MDS) (eff. October 1, 2020)</td>
</tr>
</tbody>
</table>

**COMMENT:** The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physician is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.
**OT_PHYSN_UPIN**

**LABEL:** Claim Other Physician UPIN Number

**DESCRIPTION:** On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.

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

**SHORT NAME:** OT_UPIN

**LONG NAME:** OT_PHYSN_UPIN

**TYPE:** CHAR

**LENGTH:** 6

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
LABEL: Owning Provider Tax Identification Number (TIN)

DESCRIPTION: The tax identification number (TIN) of the hospital provider used to identify ownership. Medicare’s three-day (or one-day) payment window applies to outpatient services furnished by hospitals and hospitals wholly owned or wholly operated Part B entities.

SHORT NAME: OWNG_PRVDR_TIN_NUM

LONG NAME: OWNG_PRVDR_TIN_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated prior to 2021. Applies to hospital, types of bill (TOBs) 011x, 013x, and 014x, claims transmitted to CWF on Effective and Term dates, when the Ownership type equals “1” (Hospital TIN is Owner) or “2” (Owned by different Hospital TIN). The Medicare contractor shall pass to CWF the Provider’s TIN in the “Owning TIN” field, when the “Ownership Type” field is blank, with all hospital 011x claims transmitted to CWF on Effective and Term dates.

The TOB is the concatenation of two variables:

Facility type (CLM_FAC_TYPE_CD)

Service classification type (CLM_SRVC_CLSFCTN_TYPE_CD).
<table>
<thead>
<tr>
<th><strong>PHYSN_ZIP_CD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
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<tr>
<td><strong>DESCRIPTION:</strong></td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong></td>
</tr>
<tr>
<td><strong>LONG NAME:</strong></td>
</tr>
<tr>
<td><strong>TYPE:</strong></td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
</tr>
</tbody>
</table>
**PPS_STD_VAL_PYMT_AMT**

**LABEL:** Standard Payment Amount

**DESCRIPTION:** This amount identifies the standardized Medicare payment amount.

**SHORT NAME:** PPS_STD_VAL_PYMT_AMT

**LONG NAME:** PPS_STD_VAL_PYMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This is the standardized amount as determined by PRICER software output. This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the hospitals.

This field is new in October 2014. This field applied only to inpatient claims until July 2018, when it also applied to home health agency (HHA) claims. For HHA claims, this field was initially called FINL_STD_AMT in the CCW RIF.

**NOTE:** An additional field is available that further adjusts the standard Medicare Payment amount by applying additional standardization requirements (e.g., sequestration). Refer to variable called the final standardized amount (FINL_STD_AMT).

[^ Back to TOC ^]
### Claim Procedure Code Date

**LABEL:** Claim Procedure Code Date  
**DESCRIPTION:** The date on which the procedure was performed. The date associated with the procedure identified in the corresponding ICD_PRCDR_CD#.

**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  
- PRCDR_DT14  
- PRCDR_DT15  
- PRCDR_DT16  
- PRCDR_DT17  
- PRCDR_DT18  
- PRCDR_DT19  
- PRCDR_DT20  
- PRCDR_DT21  
- PRCDR_DT22  
- PRCDR_DT23  
- PRCDR_DT24  
- PRCDR_DT25

**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  
- PRCDR_DT14  
- PRCDR_DT15  
- PRCDR_DT16  
- PRCDR_DT17  
- PRCDR_DT18  
- PRCDR_DT19  
- PRCDR_DT20  
- PRCDR_DT21  
- PRCDR_DT22  
- PRCDR_DT23  
- PRCDR_DT24  
- PRCDR_DT25
<table>
<thead>
<tr>
<th>TYPE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LENGTH</td>
<td>8</td>
</tr>
<tr>
<td>SOURCE</td>
<td>NCH</td>
</tr>
<tr>
<td>VALUES</td>
<td>—</td>
</tr>
<tr>
<td>COMMENT</td>
<td>—</td>
</tr>
</tbody>
</table>
**PRF_PHYSN_NPI**

LABEL: Carrier Line Performing NPI Number

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

SHORT NAME: PRFNPI

LONG NAME: PRF_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: Effective May 2007, the NPI became the national standard identifier for covered health care providers. NPIs replaced the legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions. The UPIN is almost never populated after 2009.
## PRF_PHYSN_UPIN

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>LABEL</td>
<td>Carrier Line Performing UPIN Number</td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC). NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.</td>
</tr>
<tr>
<td>SHORT NAME</td>
<td>PRF_UPIN</td>
</tr>
<tr>
<td>LONG NAME</td>
<td>PRF_PHYSN_UPIN</td>
</tr>
<tr>
<td>TYPE</td>
<td>CHAR</td>
</tr>
<tr>
<td>LENGTH</td>
<td>12</td>
</tr>
<tr>
<td>SOURCE</td>
<td>NCH</td>
</tr>
<tr>
<td>VALUES</td>
<td>—</td>
</tr>
<tr>
<td>COMMENT</td>
<td>—</td>
</tr>
</tbody>
</table>

[^ Back to TOC ^]
**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:** NCH

**VALUES:** —

**COMMENT:** Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8).

Effective with Version ‘J,’ this field has been expanded from 5 bytes to 7 bytes to accommodate ICD-10.

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

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

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

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

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**PRTCPTNG_IND_CD**

**LABEL:** Line Provider Participating Indicator Code

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

**SHORT NAME:** PRTCPTG

**LONG NAME:** PRTCPTNG_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
1 = Participating
2 = All or some covered and allowed expenses applied to deductible participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some covered and allowed expenses applied to deductible non-participating
6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating
7 = Participating provider not accepting assignment

**COMMENT:** —
<table>
<thead>
<tr>
<th><strong>PRVDR_FULL_CCN_NUM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
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<tr>
<td><strong>SHORT NAME:</strong></td>
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<td><strong>TYPE:</strong></td>
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<td><strong>LENGTH:</strong></td>
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<tr>
<td><strong>SOURCE:</strong></td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
</tr>
</tbody>
</table>
**PRVDR_NPI**

**LABEL:**  DMERC Line-Item Supplier NPI Number

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

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

**SHORT NAME:**  SUP_NPI

**LONG NAME:**  PRVDR_NPI

**TYPE:**  CHAR

**LENGTH:**  12

**SOURCE:**  NCH

**VALUES:**  —

**COMMENT:**  —
**PRVDR_NUM (Institutional claim)**

**LABEL:** Provider Number

**DESCRIPTION:** This variable is the provider identification number of the institutional provider certified by Medicare to provide services to the beneficiary. This is the CMS Certification Number (CCN).

The first two digits indicate the state where the provider is located. As two-digit state codes have been exhausted, CMS has implemented a two-position alpha-numeric coding system for state Codes (reference the NOTE in the VALUES below). The middle two characters indicate the type of provider; and the last two digits are used as a counter for the number of providers within that state and type of provider (i.e., this is a unique but not necessarily sequential number).

**SHORT NAME:** PROVIDER

**LONG NAME:** PRVDR_NUM

**TYPE:** CHAR

**LENGTH:** 6

**SOURCE:** —

**VALUES:** The first two positions are the CCN state codes. A state may have more than one code. The following is a list of all CMS assigned state codes to be used with the CCN:

<table>
<thead>
<tr>
<th>State Code</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Arizona</td>
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<tr>
<td>01</td>
<td>Alabama</td>
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<td>02</td>
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<td>09</td>
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<td>46</td>
<td>Utah</td>
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<tr>
<td>47</td>
<td>Vermont</td>
</tr>
</tbody>
</table>
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Idaho
55 = California
56 = Canada
57 = New York
58 = West Virginia
59 = Mexico
64 = American Samoa
65 = Guam
66 = Texas
67 = Florida
68 = Florida
69 = Florida
70 = Kansas
71 = Louisiana
72 = Ohio
73 = Pennsylvania
74 = Texas
75 = California
76 = Iowa
77 = Minnesota
78 = Illinois
79 = Missouri
80 = Maryland
81 = Connecticut
82 = Massachusetts
83 = New Jersey
84 = Puerto Rico
85 = Georgia
86 = North Carolina
87 = South Carolina
88 = Tennessee
89 = Arkansas
90 = Oklahoma
91 = Colorado
92 = California
93 = Oregon
94 = Washington
95 = Louisiana
96 = New Mexico
97 = Texas
98 = Hawaii
99 = Commonwealth of the Northern Marianas Islands

Foreign Countries (exceptions: Canada and Mexico)

A0 = California
A1 = California
A2 = Florida
A3 = Louisiana
A4 = Michigan
A5 = Mississippi
A6 = Ohio
A7 = Pennsylvania
A8 = Tennessee
A9 = Texas
B0 = Kentucky
B1 = West Virginia
B2 = California
B3 = California
B4 = California
B5 = California
B6 = North Carolina

The following blocks of numbers are reserved for the facilities indicated

(NOTE: may have different meanings dependent on the type of bill [TOB]):

0001–0879: Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880–0899: Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900–0999: Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000–1199: Reserved for future use
1200–1224: Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225–1299: Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300–1399: Critical Access Hospitals (CAH)
1400–1499: Continuation of 4900–4999 series (CMHC)
1500–1799: Hospices
1800–1989: Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990–1999: Religious Nonmedical Health Care Institutions (RNHCl)
2000–2299: Long-term hospitals
2300–2499: Chronic renal disease facilities (hospital based)
2500–2899: Non-hospital renal disease treatment centers
2900–2999: Independent special purpose renal dialysis facility (1)
3000–3024: Formerly tuberculosis hospitals (numbers retired)
3025–3099: Rehabilitation hospitals
3100–3199: Continuation of Subunits of Nonprofit and Proprietary home health Agencies (7300-7399) Series (3)
3200–3299: Continuation of 4800–4899 series (CORF)
3300–3399: Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400–3499: Continuation of rural health clinics (provider-based) (3975-3999)
3500–3699: Renal disease treatment centers (hospital satellites)
3700–3799: Hospital based special purpose renal dialysis facility (1)
3800–3974: Rural health clinics (free-standing)
3975–3999: Rural health clinics (provider-based)
4000–4499: Psychiatric hospitals
4500–4599: Comprehensive outpatient Rehabilitation Facilities (CORF)
4600–4799: Community Mental Health Centers (CMHC)
4800–4899: Continuation of 4500–4599 series (CORF)
4900–4999: Continuation of 4600–4799 series (CMHC)
5000–6499: Skilled Nursing Facilities
6500–6989: CMHC/outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X
6990–6999: Numbers Reserved (formerly Christian Science)
7000–7299: Home health Agencies (HHA) (2)
7300–7399: Subunits of 'nonprofit' and 'proprietary' Home health Agencies (3)
7400–7799: Continuation of 7000–7299 series
7800–7999: Subunits of state and local governmental Home health Agencies (3)
8000–8499: Continuation of 7400–7799 series (HHA)
8500–8899: Continuation of rural health center (provider based) (3400–3499)
8900–8999: Continuation of rural health center (free-standing) (3800–3974)
9000–9799: Continuation of 8000–8499 series (HHA)
9800–9899: Transplant Centers (eff. 10/1/2007) 9900-9999: Freestanding Opioid Treatment Program (eff. 1/2021)

**NOTE:** There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

- **M** = Psychiatric Unit in Critical Access Hospital
- **R** = Rehabilitation Unit in Critical Access Hospital
- **S** = Psychiatric unit (excluded from PPS)
- **T** = Rehabilitation unit (excluded from PPS)
- **U** = Swing-Bed Hospital Designation for Short-Term Hospitals
- **V** = Alcohol drug unit (prior to 10/87 only)
- **W** = Swing-Bed Hospital Designation for long-term care hospitals
- **Y** = Swing-Bed Hospital Designation for Rehabilitation Hospitals
- **Z** = Swing Bed Designation for Critical Access Hospitals

There is also a special numbering system for assigning emergency hospital identification numbers (non-participating hospitals).

The sixth position of the provider number is as follows:

- **E** = Non-federal emergency hospital
- **F** = Federal emergency hospital

**COMMENT:** Effective October 1, 2007, the OSCAR Provider Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider Identifier (NPI). The CCN will continue to play a critical role in verifying that a provider has been Medicare certified and for what type of services.

Refer to CCW Technical Guidance document: "Getting Started with Medicare Data" for additional information regarding service setting classifications.

If you want additional information about the institutional provider, the quarterly CMS Provider of Services (POS) file contains dozens of variables that describe the characteristics of the provider. This file is updated quarterly, and effective May 2014 is available for free online from the CMS website (2005–current).
**PRVDR_NUM (DMERC claim)**

**LABEL:**  DMERC Line Supplier Provider Number

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

**SHORT NAME:**  SUPLRNUM

**LONG NAME:**  PRVDR_NUM

**TYPE:**  CHAR

**LENGTH:**  10

**SOURCE:**  NCH

**VALUES:**  —

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

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

**SHORT NAME:** HCFASPCL

**LONG NAME:** PRVDR_SPCLTY

**TYPE:** CHAR

**LENGTH:** 3

**SOURCE:** NCH

**VALUES:**

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/2003)
- 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 = Ophthamology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 23 = Sports Medicine
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = General Psychiatry
- 28 = Colorectal surgery (formerly proctology)
- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation
- 32 = Anesthesiologist Assistants (eff. 4/1/2003 — previously grouped with Certified Registered Nurse Anesthetists [CRNA])
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometrist
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Independent Diagnostic Testing Facility (IDTF)</td>
</tr>
<tr>
<td>48</td>
<td>Podiatry</td>
</tr>
<tr>
<td>49</td>
<td>Ambulatory surgical center (formerly miscellaneous)</td>
</tr>
<tr>
<td>50</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>51</td>
<td>Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>52</td>
<td>Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>53</td>
<td>Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>54</td>
<td>Medical supply company for DMER (and not included in 51–53)</td>
</tr>
<tr>
<td>55</td>
<td>Individual certified orthotist</td>
</tr>
<tr>
<td>56</td>
<td>Individual certified prosthetist</td>
</tr>
<tr>
<td>57</td>
<td>Individual certified prosthetist-orthotist</td>
</tr>
<tr>
<td>58</td>
<td>Medical supply company with registered pharmacist</td>
</tr>
<tr>
<td>59</td>
<td>Ambulance service supplier, (e.g., private ambulance companies, funeral homes, etc.)</td>
</tr>
<tr>
<td>60</td>
<td>Public health or welfare agencies (federal, state, and local)</td>
</tr>
<tr>
<td>61</td>
<td>Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)</td>
</tr>
<tr>
<td>62</td>
<td>Psychologist (billing independently)</td>
</tr>
<tr>
<td>63</td>
<td>Portable X-ray supplier</td>
</tr>
<tr>
<td>64</td>
<td>Audiologist (billing independently)</td>
</tr>
<tr>
<td>66</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>68</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>69</td>
<td>Clinical laboratory (billing independently)</td>
</tr>
<tr>
<td>70</td>
<td>Multispecialty clinic or group practice</td>
</tr>
<tr>
<td>71</td>
<td>Registered Dietician/Nutrition Professional (eff. 1/1/2002)</td>
</tr>
<tr>
<td>72</td>
<td>Pain Management (eff. 1/1/2002)</td>
</tr>
<tr>
<td>73</td>
<td>Mass Immunization Roster Biller</td>
</tr>
<tr>
<td>74</td>
<td>Radiation Therapy Centers (prior to 4/2003 this included Independent Diagnostic Testing Facilities (IDTF))</td>
</tr>
<tr>
<td>75</td>
<td>Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs — eff. 4/1/2003))</td>
</tr>
<tr>
<td>76</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>77</td>
<td>Vascular surgery</td>
</tr>
<tr>
<td>78</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>79</td>
<td>Addiction medicine</td>
</tr>
<tr>
<td>80</td>
<td>Licensed clinical social worker</td>
</tr>
<tr>
<td>81</td>
<td>Critical care (intensivists)</td>
</tr>
<tr>
<td>82</td>
<td>Hematology</td>
</tr>
<tr>
<td>83</td>
<td>Hematology/oncology</td>
</tr>
<tr>
<td>84</td>
<td>Preventive medicine</td>
</tr>
<tr>
<td>85</td>
<td>Maxillofacial surgery</td>
</tr>
<tr>
<td>86</td>
<td>Neuropsychiatry</td>
</tr>
<tr>
<td>87</td>
<td>All other suppliers (e.g., drug and department stores)</td>
</tr>
<tr>
<td>88</td>
<td>Unknown supplier/provider specialty</td>
</tr>
<tr>
<td>89</td>
<td>Certified clinical nurse specialist</td>
</tr>
<tr>
<td>90</td>
<td>Medical oncology</td>
</tr>
<tr>
<td>91</td>
<td>Surgical oncology</td>
</tr>
<tr>
<td>92</td>
<td>Radiation oncology</td>
</tr>
<tr>
<td>93</td>
<td>Emergency medicine</td>
</tr>
<tr>
<td>94</td>
<td>Interventional radiology</td>
</tr>
<tr>
<td>96</td>
<td>Optician</td>
</tr>
<tr>
<td>97</td>
<td>Physician assistant</td>
</tr>
</tbody>
</table>
98 = Gynecologist/oncologist
99 = Unknown physician specialty
A0 = Hospital (DMERCs only)
A1 = SNF (DMERCs only)
A2 = Intermediate care nursing facility (DMERCs only)
A3 = Nursing facility, other (DMERCs only)
A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/2007)
B2 = Pedorthic Personnel (eff. 10/2/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist
C6 = Hospitalist
C7 = Advanced Heart Failure and Transplant Cardiology
C8 = Medical Toxicology
C9 = Hematopoietic Cell Transplantation and Cellular Therapy

COMMENT: —
**PRVDR_STATE_CD**

**LABEL:** NCH Provider SSA State Code

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

**SHORT NAME:** PRSTATE

**LONG NAME:** PRVDR_STATE_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 01 = Alabama
- 02 = Alaska
- 03 = Arizona
- 04 = Arkansas
- 05 = California
- 06 = Colorado
- 07 = Connecticut
- 08 = Delaware
- 09 = District of Columbia
- 10 = Florida
- 11 = Georgia
- 12 = Hawaii
- 13 = Idaho
- 14 = Illinois
- 15 = Indiana
- 16 = Iowa
- 17 = Kansas
- 18 = Kentucky
- 19 = Louisiana
- 20 = Maine
- 21 = Maryland
- 22 = Massachusetts
- 23 = Michigan
- 24 = Minnesota
- 25 = Mississippi
- 26 = Missouri
- 27 = Montana
- 28 = Nebraska
- 29 = Nevada
- 30 = New Hampshire
- 31 = New Jersey
- 32 = New Mexico
- 33 = New York
- 34 = North Carolina
- 35 = North Dakota
- 36 = Ohio
- 37 = Oklahoma
- 38 = Oregon
- 39 = Pennsylvania
- 40 = Puerto Rico
- 41 = Rhode Island
- 42 = South Carolina
- 43 = South Dakota
- 44 = Tennessee
- 45 = Texas
- 46 = Utah
- 47 = Vermont
- 48 = Virgin Islands
- 49 = Virginia
- 50 = Washington
- 51 = West Virginia
- 52 = Wisconsin
- 53 = Wyoming
- 54 = Africa
- 55 = Asia
- 56 = Canada
- 57 = Central America and West Indies
- 58 = Europe
- 59 = Mexico
- 60 = Oceania
- 61 = Philippines
- 62 = South America
- 63 = U.S. Possessions
- 64 = American Samoa
65 = Guam
97 = Northern Marianas
98 = Guam
99 = Unknown or if county code =000 then this is American Samoa

COMMENT: —
PRVDR_VLDTN_TYPE_CD

LABEL: Provider Validation Type Code
DESCRIPTION: Provider Validation Type Code
SHORT NAME: PRVDR_VLDTN_TYPE_CD
LONG NAME: PRVDR_VLDTN_TYPE_CD
TYPE: CHAR
LENGTH: 2
SOURCE: NCH
VALUES: RP = Rendering Provider
OP = Operating Physician
CP = Ordering/Referring Physician
AP = Attending Physician
FA = Facility

COMMENT: The purpose of the Provider Validation Type field on the claim is to inform Common Working File (CWF) to perform an edit check to ensure that the provider that was submitted on the Prior Authorization (PA) request is the same provider on the claim.

This field was new in April 2019.
**PRVDR_ZIP**

**LABEL:** Carrier Line Performing Provider ZIP Code

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

**SHORT NAME:** PROVZIP

**LONG NAME:** PRVDR_ZIP

**TYPE:** CHAR

**LENGTH:** 9

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** —
**PTNT_DSCHRG_STUS_CD**

**LABEL:** Patient Discharge Status Code

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

**SHORT NAME:** STUS_CD

**LONG NAME:** PTNT_DSCHRG_STUS_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Unknown Value (but present in data)</td>
</tr>
<tr>
<td>01</td>
<td>Discharged to home/self-care (routine charge)</td>
</tr>
<tr>
<td>02</td>
<td>Discharged/transferred to other short term general hospital for inpatient care</td>
</tr>
<tr>
<td>03</td>
<td>Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care — (For hospitals with an approved swing bed arrangement, use Code 61 — swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 — ICF)</td>
</tr>
<tr>
<td>04</td>
<td>Discharged/transferred to intermediate care facility (ICF)</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/transferred to another type of institution for inpatient care (including distinct parts). <strong>NOTE:</strong> Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'</td>
</tr>
<tr>
<td>06</td>
<td>Discharged/transferred to home care of organized home health service organization</td>
</tr>
<tr>
<td>07</td>
<td>Left against medical advice or discontinued care</td>
</tr>
<tr>
<td>08</td>
<td>Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued eff. 10/1/2005)</td>
</tr>
<tr>
<td>09</td>
<td>Admitted as an inpatient to this hospital (eff. 3/1/1991). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient</td>
</tr>
<tr>
<td>20</td>
<td>Expired (patient did not recover)</td>
</tr>
<tr>
<td>21</td>
<td>Discharged/transferred to court/law enforcement</td>
</tr>
<tr>
<td>30</td>
<td>Still patient</td>
</tr>
<tr>
<td>40</td>
<td>Expired at home (hospice claims only)</td>
</tr>
<tr>
<td>41</td>
<td>Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (hospice claims only)</td>
</tr>
<tr>
<td>42</td>
<td>Expired — place unknown (hospice claims only)</td>
</tr>
</tbody>
</table>
43 = Discharged/transferred to a federal hospital (eff. 10/1/2003)

50 = Discharged/transferred to a hospice — home

51 = Discharged/transferred to a hospice — medical facility

61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/2001)

62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)

63 = Discharged/transferred to a long-term care hospital. (eff. 1/2002)

64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002)

65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005)

66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/2006)

69 = Discharged/transferred to a designated disaster alternative care site (starting 10/2013; applies only to particular MS-DRGs*)

70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list

71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/2001) (discontinued eff. 10/1/2005)

72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/2001) (discontinued eff. 10/1/2005)

The following codes apply only to particular MS-DRGs*, and were new in 10/2013:

81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission

82 = Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission

83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission

84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission

85 = Discharged/transferred to a designated cancer center or children’s hospital with a planned acute care hospital inpatient readmission

86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission

88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission

89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission

90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission

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

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

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

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

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

COMMENT: * MS-DRG codes where additional codes were available in October 2013 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).
**RC_MODEL_REIMBRSMRT_AMT**

**LABEL:** Revenue Center Model Reimbursement Amount

**DESCRIPTION:** This field is used to identify the “net reimbursement amount” of what Medicare would have paid for the global budget service reflected at the line level, from a hospital participating in the particular model.

**SHORT NAME:** RC_PTNT_ADD_ON_PYMT_AMT

**LONG NAME:** RC_PTNT_ADD_ON_PYMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**COMMENT:** This field is new in January 2020. This field only applies to Part A claims.

For participating hospitals within the PA model all inpatient and outpatient services (facility/technical services) are considered a part of the model/global budget services. Basically, all the services for participating hospitals would be global except for CAH Method II (where the bill type is 85X) claims lines with revenue codes 096x, 097x or 098x. The CAH Method II professional services (REV codes 096x, 097x or 098x) process as they do today, they have nothing to do with the model.

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**RC_PTNT_ADD_ON_PYMT_AMT**

**LABEL:** Revenue Center Patient/Initial Visit Add-On Payment Amount (for initial wellness visit)

**DESCRIPTION:** This field is the revenue-center Patient Initial Visit Add-On Amount. This field represents a base rate increase factor of 1.3516 for new patient initial preventive physical examination (IPPE) and annual wellness visit.

**SHORT NAME:** RC_PTNT_ADD_ON_PYMT_AMT

**LONG NAME:** RC_PTNT_ADD_ON_PYMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is new in October 2014. This field only applies to outpatient claims.

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RC_VLNTRY_SRVC_IND_CD

LABEL: Revenue Center Voluntary Service Indicator Code

DESCRIPTION: Effective with Version ‘L’ of the NCH layout, this line level field will be used to identify if the service (procedure code) was voluntary or required.

SHORT NAME: RC_VLNTRY_SRVC_IND_CD

LONG NAME: RC_VLNTRY_SRVC_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: $V$ = A voluntary procedure code
Null/missing = A required procedure code

COMMENT: This field was new in January 2021.
**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:** NCH

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

- The values listed below may not be complete or current
- 0001 = Total charge
- 0022 = SNF claim paid under PPS submitted as type of bill (TOB) 21X
- 0023 = Home health services paid under PPS submitted as TOB 32X and 33X, eff. 10/2000. This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
- 0024 = Inpatient rehabilitation facility services paid under PPS submitted as TOB 11X, eff. for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/2001). This code may appear only once on a claim
- 0100 = All-inclusive rate — room and board plus ancillary
- 0101 = All-inclusive rate — room and board
- 0110 = Private medical or general — general classification
- 0111 = Private medical or general — medical/surgical/GYN
- 0112 = Private medical or general — OB
- 0113 = Private medical or general — pediatric
- 0114 = Private medical or general — psychiatric
- 0115 = Private medical or general — hospice
- 0116 = Private medical or general — detoxification
- 0117 = Private medical or general — oncology
- 0118 = Private medical or general — rehabilitation
- 0119 = Private medical or general — other
0120 = Semi-private 2 bed (medical or general) general classification
0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
0122 = Semi-private 2 bed (medical or general) — OB
0123 = Semi-private 2 bed (medical or general) — pediatric
0124 = Semi-private 2 bed (medical or general) — psychiatric
0125 = Semi-private 2 bed (medical or general) — hospice
0126 = Semi-private 2 bed (medical or general) — detoxification
0127 = Semi-private 2 bed (medical or general) — oncology
0128 = Semi-private 2 bed (medical or general) — rehabilitation
0129 = Semi-private 2 bed (medical or general) — other
0130 = Semi-private 3 and 4 beds — general classification
0131 = Semi-private 3 and 4 beds — medical/surgical/GYN
0132 = Semi-private 3 and 4 beds — OB
0133 = Semi-private 3 and 4 beds — pediatric
0134 = Semi-private 3 and 4 beds — psychiatric
0135 = Semi-private 3 and 4 beds — hospice
0136 = Semi-private 3 and 4 beds — detoxification
0137 = Semi-private 3 and 4 beds — oncology
0138 = Semi-private 3 and 4 beds — rehabilitation
0139 = Semi-private 3 and 4 beds — other
0140 = Private (deluxe)-general classification
0141 = Private (deluxe) — medical/surgical/GYN
0142 = Private (deluxe) — OB
0143 = Private (deluxe) — pediatric
0144 = Private (deluxe) — psychiatric
0145 = Private (deluxe) — hospice
0146 = Private (deluxe) — detoxification
0147 = Private (deluxe) — oncology
0148 = Private (deluxe) — rehabilitation
0149 = Private (deluxe) — other
0150 = Room and Board ward (medical or general) — general classification
0151 = Room and Board ward (medical or general) — medical/surgical/GYN
0152 = Room and Board ward (medical or general) — OB
0153 = Room and Board ward (medical or general) — pediatric
0154 = Room and Board ward (medical or general) — psychiatric
0155 = Room and Board ward (medical or general) — hospice
0156 = Room and Board ward (medical or general) — detoxification
0157 = Room and Board ward (medical or general) — oncology
0158 = Room and Board ward (medical or general) — rehabilitation

0159 = Room and Board ward (medical or general) — other

0160 = Other Room and Board — general classification

0161 = Hospital at home, RandB/hospital at home (eff. for claims received on or after July 1, 2022)

0164 = Other Room and Board — sterile environment

0167 = Other Room and Board — self care

0169 = Other Room and Board — other

0170 = Nursery-general classification

0171 = Nursery — newborn level I (routine)

0172 = Nursery — premature newborn-level II (continuing care)

0173 = Nursery — newborn-level III (intermediate care)

0174 = Nursery — newborn-level IV (intensive care)

0179 = Nursery — other

0180 = Leave of absence — general classification

0182 = Leave of absence — patient convenience charges billable

0183 = Leave of absence — therapeutic leave

0184 = Leave of absence-ICF mentally retarded — any reason

0185 = Leave of absence nursing home (hospitalization)

0189 = Leave of absence — other leave of absence

0190 = Subacute care — general classification

0191 = Subacute care — level I

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0193 = Subacute care — level III

0194 = Subacute care — level IV

0199 = Subacute care — other

0200 = Intensive care — general classification

0201 = Intensive care — surgical

0202 = Intensive care — medical

0203 = Intensive care — pediatric

0204 = Intensive care — psychiatric

0206 = Intensive care—post ICU; redefined as intermediate ICU

0207 = Intensive care — burn care

0208 = Intensive care — trauma

0209 = Intensive care — other intensive care

0210 = Coronary care — general classification

0211 = Coronary care — myocardial infarction

0212 = Coronary care — pulmonary care

0213 = Coronary care — heart transplant

0214 = Coronary care — post CCU; redefined as intermediate CCU
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<td>0235</td>
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0275 = Medical/surgical supplies —
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0280 = Oncology — general
classification
0289 = Oncology — other oncology
0290 = DME (other than renal) —
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0291 = DME (other than renal) —
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0292 = DME (other than renal) —
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0294 = DME (other than renal) —
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other
0300 = Laboratory — general
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0301 = Laboratory — chemistry
0302 = Laboratory — immunology
0303 = Laboratory — renal patient
(home)
0304 = Laboratory — non-routine
dialysis
0305 = Laboratory — hematology
0306 = Laboratory — bacteriology and
microbiology
0307 = Laboratory — urology
0308 = Reserved laboratory
0309 = Laboratory — other laboratory
0310 = Laboratory pathological —
general classification
0311 = Laboratory pathological — cytology
0312 = Laboratory pathological — histology
0314 = Laboratory pathological — biopsy
0319 = Laboratory pathological — other
0320 = Radiology diagnostic — general
classification
0321 = Radiology diagnostic —
angiography
0322 = Radiology diagnostic — arthrography
0323 = Radiology diagnostic — arteriography
0324 = Radiology diagnostic — chest X-ray
0327 = Reserved radiology, diagnostic
0329 = Radiology diagnostic — other
0330 = Radiology therapeutic — general
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0331 = Radiology therapeutic —
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0481 = Cardiology — cardiac cath lab
0482 = Cardiology — stress test
0483 = Cardiology — Echocardiology
0489 = Cardiology — other
0490 = Ambulatory surgical care — general classification
0499 = Ambulatory surgical care — other
0500 = Outpatient services — general classification
0509 = Outpatient services — other
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0511 = Clinic — chronic pain center
0512 = Clinic — dental center
0513 = Clinic — psychiatric
0514 = Clinic — OB-GYN
0515 = Clinic — pediatric
0516 = Clinic — urgent care clinic
0517 = Clinic — family practice clinic
0519 = Clinic — other
0520 = Free-standing clinic — general classification
0522 = Free-standing clinic — home visit by RHC/FQHC practitioner (eff. 7/1/2006). Prior to 7/1/2006 — rural health home
0523 = Free-standing clinic — family practice
0524 = Free-standing clinic — visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF. (eff. 7/1/2006)
0525 = Free-standing clinic — visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/2006)
0526 = Free-standing clinic — urgent care (eff. 10/1996)
0527 = Free-standing clinic — RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/2006)
0528 = Free-standing clinic — visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident). (eff. 7/1/2006)
0529 = Free-standing clinic — other
0530 = Osteopathic services — general classification
0531 = Osteopathic services — osteopathic therapy
0539 = Osteopathic services — other
0540 = Ambulance — general classification
0541 = Ambulance — supplies
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0610 = Magnetic resonance technology (MRT) — general classification
0611 = MRT/MRI — brain (including brainstem)
0612 = MRT/MRI — spinal cord (including spine)
0614 = MRT/MRI — other
0615 = MRT/MRA — Head and Neck
0616 = MRT/MRA — Lower Extremities
0618 = MRT/MRA — other
0619 = MRT/Other MRI
0620 = Reserved (Use 0270 for general classification)
0621 = Medical/surgical supplies — incident to radiology-subject to the payment limit — extension of 027X
0622 = Medical/surgical supplies — incident to other diagnostic service-subject to the payment limit — extension of 027X
0623 = Medical/surgical supplies — surgical dressings — extension of 027X
0624 = Medical/surgical supplies — medical investigational devices and procedures with FDA approved IDE’s — extension of 027X
0630 = Reserved
0631 = Drugs requiring specific identification — single drug source
0632 = Drugs requiring specific identification — multiple drug source
0633 = Drugs requiring specific identification — restrictive prescription
0634 = Drugs requiring specific identification — Erythropoietin (EPO) under 10,000 units
0635 = Drugs requiring specific identification — Erythropoietin (EPO) 10,000 units or more
0636 = Drugs requiring specific identification — detailed coding
0637 = Self-administered drugs administered in an emergency situation — not requiring detailed coding
0640 = Home IV therapy — general classification
0641 = Home IV therapy — nonroutine nursing
0642 = Home IV therapy — IV site care, central line
0643 = Home IV therapy — IV start/change peripheral line
0644 = Home IV therapy — nonroutine nursing, peripheral line
0645 = Home IV therapy — train patient/caregiver, central line
0646 = Home IV therapy — train disabled patient, central line
0647 = Home IV therapy — train patient/caregiver, peripheral line
0648 = Home IV therapy — train disabled patient, peripheral line
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0650 = Hospice services — general classification
0651 = Hospice services — routine home care
0652 = Hospice services — continuous home care-
0655 = Hospice services — inpatient care
0656 = Hospice services — general inpatient care (non-respite)
0657 = Hospice services — physician services
0659 = Hospice services — other
0660 = Respite care (HHA) — general classification
0661 = Respite care (HHA) — hourly charge/skilled nursing
0662 = Respite care (HHA) — hourly charge/home health aide/homemaker
0663 = Respite care (HHA) - daily respite charge
0670 = OP special residence charges — general classification
0671 = OP special residence charges — hospital based
0672 = OP special residence charges — contracted
0679 = OP special residence charges — other special residence charges
0680 = Trauma Response — not used
0681 = Trauma response — Level I Trauma
0682 = Trauma response — Level II Trauma
0683 = Trauma response — Level III Trauma
0684 = Trauma response — Level IV Trauma
0689 = Trauma response — Other trauma response
0690 = Pre-hospice/Palliative Care Services — general (eff. 7/1/2017)
0691 = Pre-hospice/Palliative Care Services — visit (eff. 7/1/2017)
0692 = Pre-hospice/Palliative Care Services — hourly (eff. 7/1/2017)
0693 = Pre-hospice/Palliative Care Services — evaluation (eff. 7/1/2017)
0694 = Pre-hospice/Palliative Care Services — consultation and education (eff. 7/1/2017)
0695 = Pre-hospice/Palliative Care Services — Inpatient (eff. 7/1/2017)
0696 = Pre-hospice/Palliative Care Services — Physician (eff. 7/1/2017)
0699 = Pre-hospice/Palliative Care Services — Other (eff. 7/1/2017)
0700 = Cast room — general classification
0709 = Cast room — other
0710 = Recovery room — general classification
0719 = Recovery room — other
0720 = Labor room/delivery — general classification
0721 = Labor room/delivery — labor
0722 = Labor room/delivery — delivery
0723 = Labor room/delivery — circumcision
0724 = Labor room/delivery — birthing center
0729 = Labor room/delivery — other
0730 = EKG/ECG Electrocardiogram — general classification
0731 = EKG/ECG — Holter monitor
0732 = EKG/ECG — telemetry
0739 = EKG/ECG — other
0740 = EEG Electroencephalogram — general classification
0743 = Reserved electroencephalogram (EEG)
0749 = EEG (electroencephalogram) — other
0750 = Gastro-intestinal services — general classification
0751 = Reserved gastrointestinal (GI) services
0759 = Gastro-intestinal services — other
0760 = Treatment or observation room — general classification
0761 = Treatment or observation room — treatment room
0762 = Treatment or observation room — observation room
0769 = Treatment or observation room — other
0770 = Preventive care services — general classification
0771 = Preventive care services — vaccine administration
0779 = Preventive care services — other
0780 = Telemedicine — general classification
0789 = Telemedicine — telemedicine
0790 = Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) — general classification
0799 = Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) — other
0800 = Inpatient renal dialysis — general classification
0801 = Inpatient renal dialysis — inpatient hemodialysis
0802 = Inpatient renal dialysis — inpatient peritoneal (non-CAPD)
0803 = Inpatient renal dialysis — inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
0804 = Inpatient renal dialysis — inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
0809 = Inpatient renal dialysis — other inpatient dialysis
0810 = Organ acquisition — general classification
0811 = Organ acquisition — living donor
0812 = Organ acquisition — cadaver donor
0813 = Organ acquisition — unknown donor
0814 = Organ acquisition — unsuccessful organ search-donor bank charges
0815 = Allogeneic Stem Cell Acquisition/Donor Services
0819 = Organ acquisition — other donor
0820 = Hemodialysis OP or home dialysis — general classification
0821 = Hemodialysis OP or home dialysis — hemodialysis-composite or other rate
0822 = Hemodialysis OP or home dialysis — home supplies
0823 = Hemodialysis OP or home dialysis — home equipment
0824 = Hemodialysis OP or home dialysis — maintenance/100%
0825 = Hemodialysis OP or home dialysis — support services
0829 = Hemodialysis OP or home dialysis — other
0830 = Peritoneal dialysis OP or home — general classification
0831 = Peritoneal dialysis OP or home — peritoneal-composite or other rate
0832 = Peritoneal dialysis OP or home — home supplies
0833 = Peritoneal dialysis OP or home — home equipment
0834 = Peritoneal dialysis OP or home — maintenance/100%
0835 = Peritoneal dialysis OP or home — support services
0839 = Peritoneal dialysis OP or home — other
0840 = Continuous Ambulatory Peritoneal Dialysis (CAPD) outpatient — general classification
0841 = Continuous Ambulatory Peritoneal Dialysis (CAPD) outpatient — CAPD/composite or other rate
0842 = Continuous Ambulatory Peritoneal Dialysis (CAPD) outpatient — home supplies
0843 = Continuous Ambulatory Peritoneal Dialysis (CAPD) outpatient — home equipment
0844 = Continuous Ambulatory Peritoneal Dialysis (CAPD) outpatient — maintenance/100%
0845 = Continuous Ambulatory Peritoneal Dialysis (CAPD) outpatient — support services
0849 = Continuous Ambulatory Peritoneal Dialysis (CAPD) outpatient — other
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<th>Description</th>
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<tr>
<td>0850</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) outpatient — general classification</td>
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<tr>
<td>0851</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) outpatient — CCPD/composite or other rate</td>
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<tr>
<td>0852</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) outpatient — home supplies</td>
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<tr>
<td>0853</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) outpatient — home equipment</td>
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<td>0854</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) outpatient — maintenance/100%</td>
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<tr>
<td>0855</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) outpatient — support services</td>
</tr>
<tr>
<td>0859</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) outpatient — other</td>
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<tr>
<td>0860</td>
<td>Magnetoencephalography (MEG) — general classification</td>
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<tr>
<td>0861</td>
<td>Magnetoencephalography (MEG) — MEG</td>
</tr>
<tr>
<td>0870</td>
<td>Cell/Gene Therapy - General</td>
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<tr>
<td>0871</td>
<td>Cell/Gene Therapy - Cell Collection</td>
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<tr>
<td>0872</td>
<td>Cell/Gene Therapy - Specialized Biologic Processing and Storage - Prior To Transport</td>
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<tr>
<td>0873</td>
<td>Cell/Gene Therapy - Storage and Processing After Receipt of Cells from Manufacturer</td>
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<tr>
<td>0874</td>
<td>Cell/Gene Therapy - Infusion of Modified Cells (Eff. 4/1/19)</td>
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<tr>
<td>0875</td>
<td>Cell/Gene Therapy - Injection of Modified Cells (Eff. 4/1/19)</td>
</tr>
<tr>
<td>0880</td>
<td>Miscellaneous dialysis — general classification</td>
</tr>
<tr>
<td>0881</td>
<td>Miscellaneous dialysis — ultrafiltration</td>
</tr>
<tr>
<td>0882</td>
<td>Miscellaneous dialysis — home dialysis aide visit</td>
</tr>
<tr>
<td>0889</td>
<td>Miscellaneous dialysis — other</td>
</tr>
<tr>
<td>0890</td>
<td>Other donor bank — general classification; changed to reserved for national assignment</td>
</tr>
<tr>
<td>0891</td>
<td>Special Processed Drugs - FDA Approved Cell Therapy (Eff. 4/1/19); Other donor bank — bone (retired 4/2019)</td>
</tr>
<tr>
<td>0892</td>
<td>Special Processed Drugs — FDA Approved Gene Therapy (eff. 4/2020); Other donor bank— organ (other than kidney); changed to reserved for national assignment (terminated 3/2020)</td>
</tr>
<tr>
<td>0893</td>
<td>Other donor bank — skin; changed to reserved for national assignment</td>
</tr>
<tr>
<td>0899</td>
<td>Other donor bank — other; changed to reserved for national assignment</td>
</tr>
<tr>
<td>0900</td>
<td>Behavior Health Treatment/Services — general classification (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological</td>
</tr>
</tbody>
</table>
0901 = Behavior Health
Treatment/Services — electroshock treatment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — electroshock treatment

0902 = Behavior Health
Treatment/Services — milieu therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — milieu therapy

0903 = Behavior Health
Treatment/Services — play therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — play therapy

0904 = Behavior Health
Treatment/Services — activity therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — activity therapy

0905 = Behavior Health
Treatment/Services — intensive outpatient services — psychiatric (eff. 10/2004)

0906 = Behavior Health
Treatment/Services — intensive outpatient services — chemical dependency (eff. 10/2004)

0907 = Behavior Health
Treatment/Services — community behavioral health program — day treatment (eff. 10/2004)

0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments — other

0910 = Behavioral Health
Treatment/Services — Reserved for National Assignment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — general classification

0911 = Behavioral Health
Treatment/Services — rehabilitation (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — rehabilitation

0912 = Behavioral Health
Treatment/Services — partial hospitalization — less intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — less intensive

0913 = Behavioral Health
Treatment/Services — partial hospitalization — intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — intensive

0914 = Behavioral Health
Treatment/Services — individual therapy (eff. 10/2004) prior to 10/2004 defined as Psychiatric/psychological services — individual therapy

0915 = Behavioral Health
Treatment/Services — group therapy (eff. 10/2004); prior to 10/2004 defined as
Psychiatric/psychological services — group therapy

0916 = Behavioral Health Treatment/Services — family therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — family therapy

0917 = Behavioral Health Treatment/Services — biofeedback (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — biofeedback

0918 = Behavioral Health Treatment/Services — testing (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — testing

0919 = Behavioral Health Treatment/Services — other (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services — other

0920 = Other diagnostic services — general classification

0921 = Other diagnostic services — peripheral vascular lab

0922 = Other diagnostic services — electromyelogram

0923 = Other diagnostic services — pap smear

0924 = Other diagnostic services — allergy test

0925 = Other diagnostic services — pregnancy test

0929 = Other diagnostic services — other

0931 = Medical Rehabilitation Day Program — half day

0932 = Medical Rehabilitation Day Program — Full Day

0940 = Other therapeutic services — general classification

0941 = Other therapeutic services — recreational therapy

0942 = Other therapeutic services — education/training (include diabetes diet training)

0943 = Other therapeutic services — cardiac rehabilitation

0944 = Other therapeutic services — drug rehabilitation

0945 = Other therapeutic services — alcohol rehabilitation

0946 = Other therapeutic services — routine complex medical equipment

0947 = Other therapeutic services — ancillary complex medical equipment

0948 = Other therapeutic services — pulmonary rehab

0949 = Other therapeutic services — other

0951 = Other therapeutic services — athletic training (extension of 094X)

0952 = Other therapeutic services — kinesiotherapy (extension of 094X)

0953 = Other therapeutic services — chemical dependency (drug and alcohol) (extension of 094X)
0958 = Reserved other, therapeutic services, extension of 094X
0960 = Professional fees — general classification
0961 = Professional fees — psychiatric
0962 = Professional fees — ophthalmology
0963 = Professional fees — anesthesiologist (MD)
0964 = Professional fees — anesthetist (CRNA)
0969 = Professional fees — other (NOTE: 097X is an extension of 096X)
0971 = Professional fees — laboratory
0972 = Professional fees — radiology diagnostic
0973 = Professional fees — radiology therapeutic
0974 = Professional fees — nuclear medicine
0975 = Professional fees — operating room
0976 = Professional fees — respiratory therapy
0977 = Professional fees — physical therapy
0978 = Professional fees — occupational therapy
0979 = Professional fees — speech pathology (NOTE: 098X is an extension of 096X and 097X)
0981 = Professional fees — emergency room
0982 = Professional fees — outpatient services
0983 = Professional fees — clinic
0984 = Professional fees — medical social services
0985 = Professional fees — EKG
0986 = Professional fees — EEG
0987 = Professional fees — hospital visit
0988 = Professional fees — consultation
0989 = Professional fees — private duty nurse
0990 = Patient convenience items — general classification
0991 = Patient convenience items — cafeteria/guest tray
0992 = Patient convenience items — private linen service
0993 = Patient convenience items — telephone/telegraph
0994 = Patient convenience items — tv/radio
0995 = Patient convenience items — nonpatient room rentals
0996 = Patient convenience items — late discharge charge
0997 = Patient convenience items — admission kits
0998 = Patient convenience items — beauty shop/barber
0999 = Patient convenience items — other
1000 = Behavioral health Accommodations — general

1001 = Behavioral health Accommodations — residential treatment psychiatric

1002 = Behavioral health Accommodations — residential treatment chemical dependency

1003= Behavioral health Accommodations — Supervised living

1004 = Behavioral health Accommodations — Halfway House

1005 = Behavioral health Accommodations — Group Home

1006 = Behavioral health Accommodations — Outdoor/wilderness behavioral health (eff. 7/1/17)

2100 = Alternative Therapy Services — General

2101 = Alternative Therapy Services — Acupuncture

2102 = Alternative Therapy Services — Acupressure

2103 = Alternative Therapy Services — Massage

2104 = Alternative Therapy Services — Reflexology

2105 = Alternative Therapy Services — Biofeedback

2106 = Alternative Therapy Services — Hypnosis

2109 = Alternative Therapy Services — Other

3101 = Adult Day Care — Medical and Social (hourly)

3103 = Adult Day Care — Medical and Social (daily)

3104 = Adult Day Care — Social (daily)

3105 = Adult Foster Care (daily)

3109 = Adult Day Care — other

NOTE: Following Revenue Codes reported for NHCMQ (RUGS) demo claims eff. 2/96

9000 = RUGS — no MDS assessment available

9001 = Reduced physical functions — RUGS PA1/ADL index of 4–5

9002 = Reduced physical functions — RUGS PA2/ADL index of 4–5

9003 = Reduced physical functions — RUGS PB1/ADL index of 6–8

9004 = Reduced physical functions — RUGS PB2/ADL index of 6–8

9005 = Reduced physical functions — RUGS PC1/ADL index of 9–10

9006 = Reduced physical functions — RUGS PC2/ADL index of 9–10

9007 = Reduced physical functions — RUGS PD1/ADL index of 11–15

9008 = Reduced physical functions — RUGS PD2/ADL index of 11–15

9009 = Reduced physical functions — RUGS PE1/ADL index of 16–18

9010 = Reduced physical functions — RUGS PE2/ADL index of 16–18

9011 = Behavior only problems — RUGS BA1/ADL index of 4–5
9012 = Behavior only problems — RUGS BA2/ADL index of 4–5
9013 = Behavior only problems — RUGS BB1/ADL index of 6–10
9014 = Behavior only problems — RUGS BB2/ADL index of 6–10
9015 = Impaired cognition — RUGS IA1/ADL index of 4–5
9016 = Impaired cognition — RUGS IA2/ADL index of 4–5
9017 = Impaired cognition — RUGS IB1/ADL index of 6–10
9018 = Impaired cognition — RUGS IB2/ADL index of 6–10
9019 = Clinically complex — RUGS CA1/ADL index of 4–5
9020 = Clinically complex — RUGS CA2/ADL index of 4–5d
9021 = Clinically complex — RUGS CB1/ADL index of 6–10
9022 = Clinically complex — RUGS CB2/ADL index of 6–10d
9023 = Clinically complex — RUGS CC1/ADL index of 11–16
9024 = Clinically complex — RUGS CC2/ADL index of 11–16d
9025 = Clinically complex — RUGS CD1/ADL index of 17–18
9026 = Clinically complex — RUGS CD2/ADL index of 17–18d
9027 = Special care — RUGS SSA/ADL index of 7–13
9028 = Special care — RUGS SSB/ADL index of 14–16
9029 = Special care — RUGS SSC/ADL index of 17–18
9030 = Extensive services — RUGS SE1/1 procedure
9031 = Extensive services — RUGS SE2/2 procedures
9032 = Extensive services — RUGS SE3/3 procedures
9033 = Low rehabilitation — RUGS RLA/ADL index of 4–11
9034 = Low rehabilitation — RUGS RLB/ADL index of 12–18
9035 = Medium rehabilitation — RUGS RMA/ADL index of 4–7
9036 = Medium rehabilitation — RUGS RMB/ADL index of 8–15
9037 = Medium rehabilitation — RUGS RMC/ADL index of 16–18
9038 = High rehabilitation — RUGS RHA/ADL index of 4–7
9039 = High rehabilitation — RUGS RHB/ADL index of 8–11
9040 = High rehabilitation — RUGS RHC/ADL index of 12–14
9041 = High rehabilitation — RUGS RHD/ADL index of 15–18
9042 = Very high rehabilitation — RUGS RVA/ADL index of 4–7
9043 = Very high rehabilitation — RUGS RVB/ADL index of 8–13
9044 = Very high rehabilitation — RUGS RVC/ADL index of 14–18
***Changes effective for providers entering***

**RUGS Demo Phase III as of 1/1/1997 or later**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Indexes</th>
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<tr>
<td>9019</td>
<td>Clinically complex — RUGS</td>
<td>CA1/ADL index of 11</td>
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<td>Clinically complex — RUGS</td>
<td>CA2/ADL index of 11D</td>
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<td>Clinically complex — RUGS</td>
<td>CB1/ADL index of 12-16</td>
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<td>Clinically complex — RUGS</td>
<td>CB2/ADL index of 12-16D</td>
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<td>9023</td>
<td>Clinically complex — RUGS</td>
<td>CC1/ADL index of 17-18</td>
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<td>Clinically complex — RUGS</td>
<td>CC2/ADL index of 17-18D</td>
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<td>Special care — RUGS SSA/ADL</td>
<td>index of 14</td>
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<tr>
<td>9026</td>
<td>Special care — RUGS SSB/ADL</td>
<td>index of 15–16</td>
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<tr>
<td>9027</td>
<td>Special care — RUGS SSC/ADL</td>
<td>index of 17–18</td>
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<td>9028</td>
<td>Extensive services — RUGS</td>
<td>SE1/ADL index 7–18/1 procedure</td>
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<td>Extensive services — RUGS</td>
<td>SE2/ADL index 7–18/2 procedures</td>
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<td>Extensive services — RUGS</td>
<td>SE3/ADL index 7–18/3 procedures</td>
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<td>Low rehabilitation — RUGS</td>
<td>RLA/ADL index of 4–13</td>
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<td>Low rehabilitation — RUGS</td>
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<td>High rehabilitation — RUGS</td>
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<td>RHC/ADL index of 13–18</td>
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<td>Very High rehabilitation — RUGS</td>
<td>RVA/ADL index of 4–8</td>
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<td>RVB/ADL index of 9–15</td>
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<td>Very high rehabilitation — RUGS</td>
<td>RVC/ADL index of 16</td>
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<td>Very high rehabilitation — RUGS</td>
<td>RUA/ADL index of 4–8</td>
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<td>9043</td>
<td>Very high rehabilitation — RUGS</td>
<td>RUB/ADL index of 9–15</td>
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<tr>
<td>9044</td>
<td>Ultra high rehabilitation — RUGS</td>
<td>RUC/ADL index of 16–18</td>
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**COMMENT:**
**REV_CNTR_1ST_ANSI_CD**

**LABEL:** Revenue Center 1st ANSI Code

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

**SHORT NAME:** REVANSI1

**LONG NAME:** REV_CNTR_1ST_ANSI_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** This code set is an external code set maintained by X12 [https://x12.org/codes](https://x12.org/codes)

*****EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES. List may not be complete or current******

**********POSITIONS 1 and 2 OF ANSI CODE**********

- CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

- PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

- CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

- PR = Patient Responsibility — this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

- OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment.

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

- 1 = Deductible Amount
- 2 = Coinsurance Amount
- 3 = Co-pay Amount
4 = The procedure code is inconsistent with the modifier used or a required modifier is missing

5 = The procedure code/bill type is inconsistent with the place of service

6 = The procedure code is inconsistent with the patient's age

7 = The procedure code is inconsistent with the patient's gender

8 = The procedure code is inconsistent with the provider type

9 = The diagnosis is inconsistent with the patient's age

10 = The diagnosis is inconsistent with the patient's gender

11 = The diagnosis is inconsistent with the procedure

12 = The diagnosis is inconsistent with the provider type

13 = The date of death precedes the date of service

14 = The date of birth follows the date of service

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

16 = Claim/service lacks information which is needed for adjudication

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete

18 = Duplicate claim/service

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier

20 = Claim denied because this injury/illness is covered by the liability carrier

21 = Claim denied because this injury/illness is the liability of the no-fault carrier

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits

23 = Claim adjusted because charges have been paid by another payer

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

25 = Payment denied. Your Stop loss deductible has not been met

26 = Expenses incurred prior to coverage

27 = Expenses incurred after coverage terminated

28 = Coverage not in effect at the time the service was provided

29 = The time limit for filing has expired

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements

31 = Claim denied as patient cannot be identified as our insured

32 = Our records indicate that this dependent is not an eligible dependent as defined
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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>33</td>
<td>Claim denied. Insured has no dependent coverage</td>
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<tr>
<td>34</td>
<td>Claim denied. Insured has no coverage for newborns</td>
</tr>
<tr>
<td>35</td>
<td>Benefit maximum has been reached</td>
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<tr>
<td>36</td>
<td>Balance does not exceed copayment amount</td>
</tr>
<tr>
<td>37</td>
<td>Balance does not exceed deductible amount</td>
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<tr>
<td>38</td>
<td>Services not provided or authorized by designated (network) providers</td>
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<tr>
<td>39</td>
<td>Services denied at the time authorization/pre-certification was requested</td>
</tr>
<tr>
<td>40</td>
<td>Charges do not meet qualifications for emergency/urgent care</td>
</tr>
<tr>
<td>41</td>
<td>Discount agreed to in Preferred Provider contract</td>
</tr>
<tr>
<td>42</td>
<td>Charges exceed our fee schedule or maximum allowable amount</td>
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<tr>
<td>43</td>
<td>Gramm-Rudman reduction</td>
</tr>
<tr>
<td>44</td>
<td>Prompt-pay discount</td>
</tr>
<tr>
<td>45</td>
<td>Charges exceed your contracted/legislated fee arrangement</td>
</tr>
<tr>
<td>46</td>
<td>This (these) service(s) is(are) not covered</td>
</tr>
<tr>
<td>47</td>
<td>This (these) diagnosis(es) is(are) not covered, missing, or are invalid</td>
</tr>
<tr>
<td>48</td>
<td>This (these) procedure(s) is(are) not covered</td>
</tr>
<tr>
<td>49</td>
<td>These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam</td>
</tr>
<tr>
<td>50</td>
<td>These are non-covered services because this is not deemed a 'medical necessity' by the payer</td>
</tr>
<tr>
<td>51</td>
<td>These are non-covered services because this a pre-existing condition</td>
</tr>
<tr>
<td>52</td>
<td>The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed</td>
</tr>
<tr>
<td>53</td>
<td>Services by an immediate relative or a member of the same household are not covered</td>
</tr>
<tr>
<td>54</td>
<td>Multiple physicians/assistants are not covered in this case</td>
</tr>
<tr>
<td>55</td>
<td>Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer</td>
</tr>
<tr>
<td>56</td>
<td>Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer</td>
</tr>
<tr>
<td>57</td>
<td>Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage</td>
</tr>
<tr>
<td>58</td>
<td>Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>59</td>
<td>Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules</td>
</tr>
<tr>
<td>60</td>
<td>Charges for outpatient services with the proximity to inpatient services are not covered</td>
</tr>
<tr>
<td>61</td>
<td>Charges adjusted as penalty for failure to obtain second surgical opinion</td>
</tr>
<tr>
<td>62</td>
<td>Claim/service denied/reduced for absence of, or exceeded, precertification/authorization</td>
</tr>
<tr>
<td>63</td>
<td>Correction to a prior claim. INACTIVE</td>
</tr>
<tr>
<td>64</td>
<td>Denial reversed per Medical Review. INACTIVE</td>
</tr>
<tr>
<td>65</td>
<td>Procedure code was incorrect. This payment reflects the correct code. INACTIVE</td>
</tr>
<tr>
<td>66</td>
<td>Blood Deductible</td>
</tr>
<tr>
<td>67</td>
<td>Lifetime reserve days. INACTIVE</td>
</tr>
<tr>
<td>68</td>
<td>DRG weight. INACTIVE</td>
</tr>
<tr>
<td>69</td>
<td>Day outlier amount</td>
</tr>
<tr>
<td>70</td>
<td>Cost outlier amount</td>
</tr>
<tr>
<td>71</td>
<td>Primary Payer amount</td>
</tr>
<tr>
<td>72</td>
<td>Coinsurance day. INACTIVE</td>
</tr>
<tr>
<td>73</td>
<td>Administrative days. INACTIVE</td>
</tr>
<tr>
<td>74</td>
<td>Indirect Medical Education Adjustment</td>
</tr>
<tr>
<td>75</td>
<td>Direct Medical Education Adjustment</td>
</tr>
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<td>76</td>
<td>Disproportionate Share Adjustment</td>
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<td>77</td>
<td>Covered days. INACTIVE</td>
</tr>
<tr>
<td>78</td>
<td>Non-covered days/room charge adjustment</td>
</tr>
<tr>
<td>79</td>
<td>Cost report days. INACTIVE</td>
</tr>
<tr>
<td>80</td>
<td>Outlier days. INACTIVE</td>
</tr>
<tr>
<td>81</td>
<td>Discharges. INACTIVE</td>
</tr>
<tr>
<td>82</td>
<td>PIP days. INACTIVE</td>
</tr>
<tr>
<td>83</td>
<td>Total visits. INACTIVE</td>
</tr>
<tr>
<td>84</td>
<td>Capital adjustments. INACTIVE</td>
</tr>
<tr>
<td>85</td>
<td>Interest amount. INACTIVE</td>
</tr>
<tr>
<td>86</td>
<td>Statutory adjustment. INACTIVE</td>
</tr>
<tr>
<td>87</td>
<td>Transfer amounts</td>
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<td>88</td>
<td>Adjustment amount represents collection against receivable created in prior overpayment</td>
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<tr>
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<td>Ingredient cost adjustment</td>
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<td>91</td>
<td>Dispensing fee adjustment</td>
</tr>
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<td>92</td>
<td>Claim paid in full. INACTIVE</td>
</tr>
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<td>No claim level adjustment. INACTIVE</td>
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<td>Benefits adjusted. Plan procedures not followed</td>
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<td>Medicare Secondary Payer Adjustment Amount. INACTIVE</td>
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<td>Code</td>
<td>Description</td>
</tr>
<tr>
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<td>Payment made to patient/insured/responsible party</td>
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<td>Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor</td>
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<td>Billing date predates service date</td>
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<td>Patient is covered by a managed care plan. INACTIVE</td>
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<td>Indemnification adjustment</td>
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<tr>
<td>122</td>
<td>Psychiatric reduction</td>
</tr>
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<td>123</td>
<td>Payer refund due to overpayment. INACTIVE</td>
</tr>
<tr>
<td>124</td>
<td>Payer refund amount — not our patient. INACTIVE</td>
</tr>
<tr>
<td>125</td>
<td>Claim/service adjusted due to a submission/billing error(s)</td>
</tr>
<tr>
<td>126</td>
<td>Deductible — major Medical</td>
</tr>
<tr>
<td>127</td>
<td>Coinsurance — major Medical</td>
</tr>
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<td>128</td>
<td>Newborn's services are covered in the mother's allowance</td>
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<td>Claim denied — prior processing information appears incorrect</td>
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<td>130</td>
<td>Paper claim submission fee</td>
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<td>138</td>
<td>Claim/service denied. Appeal procedures not followed, or time limits not met</td>
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<td>139</td>
<td>Contracted funding agreement — subscriber is employed by the provider of services</td>
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<td>Patient/Insured health identification number and name do not match</td>
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<tr>
<td>141</td>
<td>Claim adjustment because the claim spans eligible and ineligible periods of coverage</td>
</tr>
<tr>
<td>142</td>
<td>Claim adjusted by the monthly Medicaid patient liability amount</td>
</tr>
<tr>
<td>A0</td>
<td>Patient refund amount</td>
</tr>
<tr>
<td>A1</td>
<td>Claim denied charges</td>
</tr>
<tr>
<td>A2</td>
<td>Contractual adjustment</td>
</tr>
<tr>
<td>A3</td>
<td>Medicare Secondary Payer liability met. INACTIVE</td>
</tr>
<tr>
<td>A4</td>
<td>Medicare Claim PPS Capital Day Outlier Amount</td>
</tr>
<tr>
<td>A5</td>
<td>Medicare Claim PPS Capital Cost Outlier Amount</td>
</tr>
<tr>
<td>A6</td>
<td>Prior hospitalization or 30-day transfer requirement not met</td>
</tr>
<tr>
<td>A7</td>
<td>Presumptive Payment Adjustment</td>
</tr>
<tr>
<td>A8</td>
<td>Claim denied; ungroupable DRG</td>
</tr>
<tr>
<td>B1</td>
<td>Non-covered visits</td>
</tr>
<tr>
<td>B2</td>
<td>Covered visits. INACTIVE</td>
</tr>
<tr>
<td>B3</td>
<td>Covered charges. INACTIVE</td>
</tr>
<tr>
<td>B4</td>
<td>Late filing penalty</td>
</tr>
<tr>
<td>B5</td>
<td>Claim/service adjusted because coverage/program guidelines were not met or were exceeded</td>
</tr>
<tr>
<td>B6</td>
<td>This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty</td>
</tr>
<tr>
<td>B7</td>
<td>This provider was not certified/eligible to be paid for this procedure/service on this date of service</td>
</tr>
<tr>
<td>B8</td>
<td>Claim/service not covered/reduced because alternative services were available and should have been utilized</td>
</tr>
<tr>
<td>B9</td>
<td>Services not covered because the patient is enrolled in a Hospice</td>
</tr>
<tr>
<td>B10</td>
<td>Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test</td>
</tr>
</tbody>
</table>
B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor

B12 = Services not documented in patients' medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Claim/service denied because only one visit or consultation per physician per day is covered

B15 = Claim/service adjusted because this procedure/service is not paid separately

B16 = Claim/service adjusted because 'New Patient' qualifications were not met

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission

B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider

B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE

B22 = This claim/service is adjusted based on the diagnosis

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program

W1 = Workers Compensation State Fee Schedule Adjustment

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.
**REV_CNTR_1ST_MSP_PD_AMT**

**LABEL:** Revenue Center 1st Medicare Secondary Payer (MSP) Paid Amount

**DESCRIPTION:** The amount paid by the primary payer when the payer is primary to Medicare (Medicare is a secondary).

**SHORT NAME:** REV_MSP1

**LONG NAME:** REV_CNTR_1ST_MSP_PD_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

[^ Back to TOC ^]
**REV_CNTR_2ND_ANSI_CD**

**LABEL:** Revenue Center 2nd ANSI Code

**DESCRIPTION:** The second code used to identify the detailed reason an adjustment was made (e.g., reason for denial or reducing payment).

**SHORT NAME:** REVANSI2

**LONG NAME:** REV_CNTR_2ND_ANSI_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** **********EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******

**********POSITIONS 1 and 2 OF ANSI CODE**********

CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility — this group code should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount
2 = Coinsurance Amount
3 = Co-pay Amount
4 = The procedure code is inconsistent with the modifier used or a required modifier is missing
5 = The procedure code/bill type is inconsistent with the place of service
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>The procedure code is inconsistent with the patient's age</td>
</tr>
<tr>
<td>7</td>
<td>The procedure code is inconsistent with the patient's gender</td>
</tr>
<tr>
<td>8</td>
<td>The procedure code is inconsistent with the provider type</td>
</tr>
<tr>
<td>9</td>
<td>The diagnosis is inconsistent with the patient's age</td>
</tr>
<tr>
<td>10</td>
<td>The diagnosis is inconsistent with the patient's gender</td>
</tr>
<tr>
<td>11</td>
<td>The diagnosis is inconsistent with the procedure</td>
</tr>
<tr>
<td>12</td>
<td>The diagnosis is inconsistent with the provider type</td>
</tr>
<tr>
<td>13</td>
<td>The date of death precedes the date of service</td>
</tr>
<tr>
<td>14</td>
<td>The date of birth follows the date of service</td>
</tr>
<tr>
<td>15</td>
<td>Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider</td>
</tr>
<tr>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication</td>
</tr>
<tr>
<td>17</td>
<td>Claim/service adjusted because requested information was not provided or was insufficient/incomplete</td>
</tr>
<tr>
<td>18</td>
<td>Duplicate claim/service</td>
</tr>
<tr>
<td>19</td>
<td>Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier</td>
</tr>
<tr>
<td>20</td>
<td>Claim denied because this injury/illness is covered by the liability carrier</td>
</tr>
<tr>
<td>21</td>
<td>Claim denied because this injury/illness is the liability of the no-fault carrier</td>
</tr>
<tr>
<td>22</td>
<td>Claim adjusted because this care may be covered by another payer per coordination of benefits</td>
</tr>
<tr>
<td>23</td>
<td>Claim adjusted because charges have been paid by another payer</td>
</tr>
<tr>
<td>24</td>
<td>Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan</td>
</tr>
<tr>
<td>25</td>
<td>Payment denied. Your Stop loss deductible has not been met</td>
</tr>
<tr>
<td>26</td>
<td>Expenses incurred prior to coverage</td>
</tr>
<tr>
<td>27</td>
<td>Expenses incurred after coverage terminated</td>
</tr>
<tr>
<td>28</td>
<td>Coverage not in effect at the time the service was provided</td>
</tr>
<tr>
<td>29</td>
<td>The time limit for filing has expired</td>
</tr>
<tr>
<td>30</td>
<td>Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements</td>
</tr>
<tr>
<td>31</td>
<td>Claim denied as patient cannot be identified as our insured</td>
</tr>
<tr>
<td>32</td>
<td>Our records indicate that this dependent is not an eligible dependent as defined</td>
</tr>
<tr>
<td>33</td>
<td>Claim denied. Insured has no dependent coverage</td>
</tr>
<tr>
<td>34</td>
<td>Claim denied. Insured has no coverage for newborns</td>
</tr>
<tr>
<td>35</td>
<td>Benefit maximum has been reached</td>
</tr>
<tr>
<td>36</td>
<td>Balance does not exceed copayment amount</td>
</tr>
<tr>
<td>37</td>
<td>Balance does not exceed deductible amount</td>
</tr>
</tbody>
</table>
38 = Services not provided or authorized by designated (network) providers

39 = Services denied at the time authorization/pre-certification was requested

40 = Charges do not meet qualifications for emergency/urgent care

41 = Discount agreed to in Preferred Provider contract

42 = Charges exceed our fee schedule or maximum allowable amount

43 = Gramm-Rudman reduction

44 = Prompt-pay discount

45 = Charges exceed your contracted/legislated fee arrangement

46 = This (these) service(s) is(are) not covered

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid

48 = This (these) procedure(s) is(are) not covered

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer

51 = These are non-covered services because this a pre-existing condition

52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed

53 = Services by an immediate relative or a member of the same household are not covered

54 = Multiple physicians/assistants are not covered in this case

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules

60 = Charges for outpatient services with the proximity to inpatient services are not covered

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A0 = Patient refund amount

A1 = Claim denied charges

A2 = Contractual adjustment

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount

A6 = Prior hospitalization or 30-day transfer requirement not met

A7 = Presumptive Payment Adjustment

A8 = Claim denied; ungroupable DRG

B1 = Non-covered visits

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized

B9 = Services not covered because the patient is enrolled in a hospice

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor

B12 = Services not documented in patients' medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Claim/service denied because only one visit or consultation per physician per day is covered
B15 = Claim/service adjusted because this procedure/service is not paid separately

B16 = Claim/service adjusted because 'New Patient' qualifications were not met

B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission

B19 = Claim/service adjusted because of the finding of a Review Organization.
INACTIVE

B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider

B21 = The charges were reduced because the service/care was partially furnished by another physician.
INACTIVE

B22 = This claim/service is adjusted based on the diagnosis

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program

W1 = Workers Compensation State Fee Schedule Adjustment

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.
**REV_CNTR_2ND_MSP_PD_AMT**

**LABEL:** Revenue Center 2nd Medicare Secondary Payer (MSP) Paid Amount

**DESCRIPTION:** The amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

**SHORT NAME:** REV_MSP2

**LONG NAME:** REV_CNTR_2ND_MSP_PD_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.
**REV_CNTR_3RD_ANSI_CD**

**LABEL:** Revenue Center 3rd ANSI Code

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

**SHORT NAME:** REVANSI3

**LONG NAME:** REV_CNTR_3RD_ANSI_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:**

*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******

**************POSITIONS 1 and 2 OF ANSI CODE**************

CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility — this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

***********Claim Adjustment Reason Codes***********

***********POSITIONS 3 through 5 of ANSI CODE***********

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing

5 = The procedure code/bill type is inconsistent with the place of service

6 = The procedure code is inconsistent with the patient’s age

7 = The procedure code is inconsistent with the patient’s gender
8 = The procedure code is inconsistent with the provider type
9 = The diagnosis is inconsistent with the patient's age
10 = The diagnosis is inconsistent with the patient's gender
11 = The diagnosis is inconsistent with the procedure
12 = The diagnosis is inconsistent with the provider type
13 = The date of death precedes the date of service
14 = The date of birth follows the date of service
15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider
16 = Claim/service lacks information which is needed for adjudication
17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete
18 = Duplicate claim/service
19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier
20 = Claim denied because this injury/illness is covered by the liability carrier
21 = Claim denied because this injury/illness is the liability of the no-fault carrier
22 = Claim adjusted because this care may be covered by another payer per coordination of benefits
23 = Claim adjusted because charges have been paid by another payer
24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan
25 = Payment denied. Your Stop loss deductible has not been met
26 = Expenses incurred prior to coverage
27 = Expenses incurred after coverage terminated
28 = Coverage not in effect at the time the service was provided
29 = The time limit for filing has expired
30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements
31 = Claim denied as patient cannot be identified as our insured
32 = Our records indicate that this dependent is not an eligible dependent as defined
33 = Claim denied. Insured has no dependent coverage
34 = Claim denied. Insured has no coverage for newborns
35 = Benefit maximum has been reached
36 = Balance does not exceed copayment amount
37 = Balance does not exceed deductible amount

38 = Services not provided or authorized by designated (network) providers

39 = Services denied at the time authorization/pre-certification was requested

40 = Charges do not meet qualifications for emergency/urgent care

41 = Discount agreed to in Preferred Provider contract

42 = Charges exceed our fee schedule or maximum allowable amount

43 = Gramm-Rudman reduction

44 = Prompt-pay discount

45 = Charges exceed your contracted/legislated fee arrangement

46 = This (these) service(s) is(are) not covered

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid

48 = This (these) procedure(s) is(are) not covered

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer

51 = These are non-covered services because this a pre-existing condition

52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed

53 = Services by an immediate relative or a member of the same household are not covered

54 = Multiple physicians assistants are not covered in this case

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules

60 = Charges for outpatient services with the proximity to inpatient services are not covered

61 = Charges adjusted as penalty for failure to obtain second surgical opinion

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization
63 = Correction to a prior claim. INACTIVE
64 = Denial reversed per Medical Review. INACTIVE
65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
66 = Blood Deductible
67 = Lifetime reserve days. INACTIVE
68 = DRG weight. INACTIVE
69 = Day outlier amount
70 = Cost outlier amount
71 = Primary Payer amount
72 = Coinsurance day. INACTIVE
73 = Administrative days. INACTIVE
74 = Indirect Medical Education Adjustment
75 = Direct Medical Education Adjustment
76 = Disproportionate Share Adjustment
77 = Covered days. INACTIVE
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92 = Claim paid in full. INACTIVE
93 = No claim level adjustment. INACTIVE
94 = Process in excess of charges
95 = Benefits adjusted. Plan procedures not followed
96 = Non-covered charges
97 = Payment is included in allowance for another service/procedure
98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
100 = Payment made to patient/insured/responsible party
101 = Predetermination: anticipated payment upon completion of services or claim adjudication
102 = Major medical adjustment
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117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care
118 = Charges reduced for ESRD network support
119 = Benefit maximum for this time period has been reached
120 = Patient is covered by a managed care plan. INACTIVE
121 = Indemnification adjustment
122 = Psychiatric reduction
123 = Payer refund due to overpayment. INACTIVE
124 = Payer refund amount — not our patient. INACTIVE
125 = Claim/service adjusted due to a submission/billing error(s)
126 = Deductible — Major Medical
127 = Coinsurance — Major Medical
128 = Newborn's services are covered in the mother's allowance
129 = Claim denied — prior processing information appears incorrect
130 = Paper claim submission fee
131 = Claim specific negotiated discount
132 = Prearranged demonstration project adjustment
133 = The disposition of this claim/service is pending further review
134 = Technical fees removed from charges
135 = Claim denied. Interim bills cannot be processed
136 = Claim adjusted. Plan procedures of a prior payer were not followed
137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes
138 = Claim/service denied. Appeal procedures not followed, or time limits not met
139 = Contracted funding agreement — subscriber is employed by the provider of services
140 = Patient/Insured health identification number and name do not match
141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage
142 = Claim adjusted by the monthly Medicaid patient liability amount
A0 = Patient refund amount
A1 = Claim denied charges
A2 = Contractual adjustment
A3 = Medicare Secondary Payer liability met. INACTIVE
A4 = Medicare Claim PPS Capital Day Outlier Amount
A5 = Medicare Claim PPS Capital Cost Outlier Amount
A6 = Prior hospitalization or 30-day transfer requirement not met
A7 = Presumptive Payment Adjustment
A8 = Claim denied; ungroupable DRG
B1 = Non-covered visits
B2 = Covered visits. INACTIVE
B3 = Covered charges. INACTIVE
B4 = Late filing penalty
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B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty
B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service
B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized
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B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission
B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE
B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider
B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE
B22 = This claim/service is adjusted based on the diagnosis
B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program
W1 = Workers Compensation State Fee Schedule Adjustment

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.
**REV_CNTR_4TH_ANSI_CD**

**LABEL:** Revenue Center 4th ANSI Code

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

**SHORT NAME:** REVANSI4

**LONG NAME:** REV_CNTR_4TH_ANSI_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:**  

*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******

**************POSITIONS 1 and 2 OF ANSI CODE***************

CO = Contractual Obligations — this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals — this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments — this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions — this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility — this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing

5 = The procedure code/bill type is inconsistent with the place of service

6 = The procedure code is inconsistent with the patient’s age

7 = The procedure code is inconsistent with the patient’s gender
<table>
<thead>
<tr>
<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>The procedure code is inconsistent with the provider type</td>
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<tr>
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134 = Technical fees removed from charges

135 = Claim denied. Interim bills cannot be processed

136 = Claim adjusted. Plan procedures of a prior payer were not followed
137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes

138 = Claim/service denied. Appeal procedures not followed, or time limits not met

139 = Contracted funding agreement — subscriber is employed by the provider of services

140 = Patient/Insured health identification number and name do not match

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage

142 = Claim adjusted by the monthly Medicaid patient liability amount

A0 = Patient refund amount

A1 = Claim denied charges

A2 = Contractual adjustment

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount

A5 = Medicare Claim PPS Capital Cost Outlier Amount

A6 = Prior hospitalization or 30-day transfer requirement not met

A7 = Presumptive Payment Adjustment

A8 = Claim denied; ungroupable DRG

B1 = Non-covered visits

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service

B8 = Claim/service not covered/reduced because alternative services were available and should have been utilized

B9 = Services not covered because the patient is enrolled in a hospice

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor

B12 = Services not documented in patients' medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Claim/service denied because only one visit or consultation per physician per day is covered
COMMENT: This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Valid beginning with NCH weekly process date 7/7/2000.
**REV_CNTR_ADJUST_GRP_CD**

**LABEL:** Revenue Center Adjustment Group Code

**DESCRIPTION:** Claim adjustment group code used to categorize a payment adjustment for a claim or claim line. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

**SHORT NAME:** REV_CNTR_ADJUST_GRP_CD

**LONG NAME:** REV_CNTR_ADJUST_GRP_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**
- CO = Contractual obligation
- OA = Other adjustment
- PR = Patient responsibility

**COMMENT:** This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.
REV_CNTR_ADJUST_RSN_CD

LABEL: Revenue Center Adjustment Reason Code

DESCRIPTION: Claim adjustment reason code used to describe why a claim or claim line was paid differently than billed. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

SHORT NAME: REV_CNTR_ADJUST_RSN_CD

LONG NAME: REV_CNTR_ADJUST_RSN_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: This is not a comprehensive list of values; refer to website below for current values and descriptions:
94 = Processed in Excess of charges
119 = Benefit maximum for this time period or occurrence has been reached
132 = Prearranged demonstration project adjustment

COMMENT: This code set is an external code set maintained by X12 (www.x12.org/codes). This field is not populated prior to 2021.
**REV_CNTR_APC_HIPPS_CD**

**LABEL:** Revenue Center APC or HIPPS Code

**DESCRIPTION:** This field contains one of two potential pieces of data; the Ambulatory Payment Classification (APC) code or the Health Insurance prospective payment system (HIPPS) code, which corresponds with the revenue center line for the claim.

The APC codes are used as the basis for payment for outpatient prospective payment (OPPS) service (e.g., Part B institutional). Additional information regarding OPPS is available on the CMS website (reference: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html).

Some Part A claim types (e.g., home health and SNF) use resource groupings, which are similar to case-mix groups, as the basis for payment (e.g., HHRG, SNF RUGs).

For home health (HH) claims, when the revenue center code (variable called REV_CNTR) is 0023, the HHRG is located in this field and is a HIPPS code. This field is only meaningful for a HH claim when CMS determines the claim should be paid using a different HIPPS code than the one submitted by the provider. When this happens, the revised HIPPS code (the one used for payment purposes) appears in this field and the original HIPPS code submitted by the provider remains in the HCPCS_CD field. Otherwise, this variable will always be null or have a value of “00000” for HH revenue center records.

The resource utilization group for the particular revenue center is located in the data field called the APC or HIPPS code variable.

The APC is a four-byte field.

The HIPPS code is a five-byte field (such as 1AFKS).

**SHORT NAME:** APCHIPPS

**LONG NAME:** REV_CNTR_APC_HIPPS_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** APC codes can be downloaded from the CMS website (reference: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html)

Examples of APC codes: 0002 = Fine needle Biopsy/Aspiration; 0812 = Carmustine injection

HIPPS codes can be downloaded from the CMS website Prospective Payment Systems page (reference: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html).

1057 = Micromark Tissue Marker (eff. 1/2001)
COMMENT: The APC field is populated for those claims that are required to process through outpatient PPS Pricer.

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

**LABEL:** Revenue Center Payment Amount to Beneficiary

**DESCRIPTION:** The amount paid to the beneficiary for the services reported on the line item.

**SHORT NAME:** RBENEPMT

**LONG NAME:** REV_CNTR_BENE_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.
**REV_CNTR_BLOOD_DDCTBL_AMT**

**LABEL:** Revenue Center Blood Deductible Amount

**DESCRIPTION:** This variable is the dollar amount the beneficiary is responsible for related to the deductible for blood products that appear on the revenue center record.

A deductible amount applies to the first 3 pints of blood (or equivalent units; applies only to whole blood or packed red cells — not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible.

**SHORT NAME:** REVBLOOD

**LONG NAME:** REV_CNTR_BLOOD_DDCTBL_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the blood deductible.

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.
**REV_CNTR_CASH_DDCTBL_AMT**

**LABEL:** Revenue Center Cash Deductible Amount

**DESCRIPTION:** This variable is the beneficiary’s liability under the annual Part B deductible for the revenue center record. The Part B deductible applies to both institutional (e.g., HOP) and non-institutional (e.g., Carrier and DME) services.

**SHORT NAME:** REVDCTBL

**LONG NAME:** REV_CNTR_CASH_DDCTBL_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles.

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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**REV_CNTR_COINSRNC_WGE_ADJSTD_C**

**LABEL:** Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount

**DESCRIPTION:** This variable is the beneficiary’s liability for coinsurance for the revenue center record.

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

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

The coinsurance amount is wage adjusted, based on the metropolitan statistical area (MSA) where the provider is located.

**SHORT NAME:** WAGEADJ

**LONG NAME:** REV_CNTR_COINSRNC_WGE_ADJSTD_C

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) “Payment System Fact Sheet Series” (reference the list of MLN publications at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html)).

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

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

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**REV_CNTR_CRA_TPNIES_AMT**

**LABEL:** Revenue Center Capital Related Assets Transitional Add-on Payment Amt New and Innovative Equip

**DESCRIPTION:** Revenue Center Capital Related Assets Adjustment (CRA) Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Amount.

This line level field represents the ESRD PPS add-on payment for capital-related assets (CRA). For eligible CRAs that are home dialysis machines, ESRD facilities will be paid the CRA for TPNIES

**SHORT NAME:** REV_CNTR_CRA_TPNIES_AMT

**LONG NAME:** REV_CNTR_CRA_TPNIES_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XXXX

**COMMENT:** This only appears on outpatient claims. This field is not populated prior to 2021.

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**REV_CNTR_DDCTBL_COINSRNC_CD**

**LABEL:** Revenue Center Deductible Coinsurance Code

**DESCRIPTION:** Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

**SHORT NAME:** REVDEDCD

**LONG NAME:** REV_CNTR_DDCTBL_COINSRNC_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
0 = Charges are subject to deductible and coinsurance
1 = Charges are not subject to deductible
2 = Charges are not subject to coinsurance
3 = Charges are not subject to deductible or coinsurance
4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:
M = Override code; EGHP (employer group health plan) services involved
N = Override code; non-EGHP services involved
X = Override code: MSP (Medicare is secondary payer) cost avoided

**COMMENT:** —
REV_CNTR_DSCNT_IND_CD

LABEL: Revenue Center Discount Indicator Code

DESCRIPTION: This code represents a factor that specifies the amount of any Ambulatory payment classification (APC) discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed.

**If there is no discounting the factor will be 1.0.**

SHORT NAME: DSCNTIND

LONG NAME: REV_CNTR_DSCNT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: *DISCOUNTING FORMULAS*
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D
6 = TD/U
7 = D(1+D)/U
8 = 2.0/U
D = Discounting fraction (currently 0.5)
U = Number of units
T = Terminated procedure discount (currently 0.5)

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

It has been discovered that this field may be populated with data on claims with dates of service prior to 7/2000 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/2000 and forward.
Data has been found in claims with dates of service prior to 7/2000 because the Standard Systems have processed any claim coming in 7/2000 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.
**REV_CNTR_DT**

**LABEL:** Revenue Center Date

**DESCRIPTION:** This is the date of service for the revenue center record. However, it is populated only for home health claims, hospice claims, and Part B institutional (HOP) claims. For home health claims, which are paid based on episodes that can last up to 60 days, this variable indicates the dates for the individual visits.

**SHORT NAME:** REV_DT

**LONG NAME:** REV_CNTR_DT

**TYPE:** DATE

**LENGTH:** 8

**SOURCE:** NCH

**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 will have a revenue center code '0624'.

SHORT NAME:  IDENDC

LONG NAME:  REV_CNTR_IDE_NDC_UPC_NUM

TYPE:  CHAR

LENGTH:  24

SOURCE:  NCH

VALUES:  —

COMMENT:  This field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). 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).

The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7).
**REV_CNTR_NCVRD_CHRG_AMT**

**LABEL:** Revenue Center Non-Covered Charge Amount

**DESCRIPTION:** The charge amount related to a revenue center code for services that are not covered by Medicare.

**SHORT NAME:** REV_NCVR

**LONG NAME:** REV_CNTR_NCVRD_CHRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** —
REV_CNTR_NDC_QTY

LABEL: Revenue Center National Drug Code (NDC) Quantity

DESCRIPTION: Effective with Version ‘J,’ 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: NCH

VALUES: —

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

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

**DESCRIPTION:** Effective with Version ‘J,’ 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:** NCH

**VALUES:**
- F2 = International Unit
- GR = Gram
- ML = Milliliter
- UN = Unit

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

**LABEL:** Revenue Center Obligation to Accept As Full (OTAF) Payment Code

**DESCRIPTION:** The code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

**SHORT NAME:** OTAF_1

**LONG NAME:** REV_CNTR_OTAF_PMT_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** —

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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**REV_CNTR_PACKG_IND_CD**

**LABEL:** Revenue Center Packaging Indicator Code

**DESCRIPTION:** The code used to identify those services that are packaged/bundled with another service.

**SHORT NAME:** PACKGIND

**LONG NAME:** REV_CNTR_PACKG_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- 0 = Not packaged
- 1 = Packaged service (service indicator N)
- 2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem
- 3 = Artificial charges for surgical procedure (eff. 7/2004)

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.
**REV_CNTR_PMT_AMT_AMT**

**LABEL:** Revenue Center (Medicare) Payment Amount

**DESCRIPTION:** To obtain the Medicare payment amount for the services reported on the revenue center record, it is more accurate to use a different variable called the revenue center Medicare provider payment amount (REV_CNTR_PRVDR_PMT_AMT).

For home health, use the claim-level Medicare payment amount (variable that is the total of all revenue center records on the claim, which is called CLM_PMT_AMT), since each visit is not paid separately.

**SHORT NAME:** REVPMT

**LONG NAME:** REV_CNTR_PMT_AMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.
**REV_CNTR_PMT_MTHD_IND_CD**

**LABEL:** Revenue Center Payment Method Indicator Code

**DESCRIPTION:** The code used to identify how the service is priced for payment.

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

**SHORT NAME:** PMTMTHD

**LONG NAME:** REV_CNTR_PMT_MTHD_IND_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Unknown Value (but present in data)</td>
</tr>
<tr>
<td>1</td>
<td>Paid standard hospital OPPS amount (status indicators K,S,T,V,X)</td>
</tr>
<tr>
<td>2</td>
<td>Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes)</td>
</tr>
<tr>
<td>3</td>
<td>Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B, C, and Z)</td>
</tr>
<tr>
<td>4</td>
<td>Paid at reasonable cost (status indicator F and L)</td>
</tr>
<tr>
<td>5</td>
<td>Additional payment for drug or biological (status indicator G)</td>
</tr>
<tr>
<td>6</td>
<td>Additional payment for device (status indicator H)</td>
</tr>
<tr>
<td>7</td>
<td>Additional payment for new drug or new biological (status indicator J)</td>
</tr>
<tr>
<td>8</td>
<td>Paid partial hospitalization per diem (status indicator P)</td>
</tr>
<tr>
<td>9</td>
<td>No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services))</td>
</tr>
</tbody>
</table>

**VALUES PRIOR TO 10/3/2005***************

**Service Status Indicator**************

**1st position **************

- **A** = Services not paid under OPPS
- **C** = Inpatient procedure
- **E** = Non-covered items or services
- **F** = Corneal tissue acquisition
- **G** = Current drug or biological pass-through
- **H** = Device pass-through
J = New drug or new biological pass-through
N = Packaged incidental service
P = Partial hospitalization services
S = Significant procedure not subject to multiple procedure discounting
T = Significant procedure subject to multiple procedure discounting
V = Medical visit to clinic or emergency department
X = Ancillary service

**********Payment Indicator**************

********** 2nd position ***************

1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)
2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)
3 = Not paid (service indicators C and E)
4 = Acquisition cost paid (service indicator F)
5 = Additional payment for current drug or biological (service indicator G)
6 = Additional payment for device (service indicator H)
7 = Additional payment for new drug or new biological (service indicator J)
8 = Paid partial hospitalization per diem (service indicator P)
9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)

**COMMENT:** Prior to 10/2005, this variable contained the valid values for both the payment indicator and status indicator. Effective 10/2005, only the payment indicator codes remain in this table and the status indicator is housed in a new field named: REV_CNTR_STUS_IND_CD (with the corresponding values in the new table: REV_CNTR_STUS_IND_TB). Both the payment indicator and status indicator values have been expanded to 2-bynes.

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.
**REV_CNTR_PRCNG_IND_CD**

**LABEL:** Revenue Center Pricing Indicator Code

**DESCRIPTION:** The code used to identify if there was a deviation from the standard method of calculating payment amount.

**SHORT NAME:** REV_CNTR_PRCNG_IND_CD

**LONG NAME:** REV_CNTR_PRCNG_IND_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.</td>
</tr>
<tr>
<td>B</td>
<td>A valid HCPCS code subject to the fee schedule payment. For the provider billed charges. <strong>NOTE:</strong> There is an exception for Critical Access Hospitals (provider numbers XX1300–XX1399) with reimbursement method 'J' (all-inclusive method) and dates of service on or after 7/1/2001. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.</td>
</tr>
<tr>
<td>C</td>
<td>Unlisted Rehabilitation Carrier Priced HCPCS</td>
</tr>
<tr>
<td>D</td>
<td>A valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.</td>
</tr>
<tr>
<td>E</td>
<td>A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report. <strong>NOTE:</strong> The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.</td>
</tr>
<tr>
<td>F</td>
<td>A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS. <strong>NOTE:</strong> The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.</td>
</tr>
<tr>
<td>G</td>
<td>A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.</td>
</tr>
<tr>
<td>H</td>
<td>A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category of DME.</td>
</tr>
</tbody>
</table>
I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.

L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review. This code will be automatically set by the system.

M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months. This must be set by Medical Review. This must be set by Medical Review when approved for payment.

N = Paid based on the fee amount for non ESRD TOB’s. NOTE: Fee amount is paid regardless of charges.

Q = Manual pricing

R = A valid radiology HCPCS code and is subject to APC. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges.

S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider’s reimbursement rate.

T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider’s reimbursement rate.

U = Valid ambulance HCPCS. A fee amount is present. The amount payable is a blended amount based on a percentage of the fee schedule and a percentage of the reasonable cost. The fee amount is subject to coinsurance and deductible.

X = Unclassified drug as subject to manual pricing.

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

It has been discovered that this field may be populated with data on claims with dates of service prior to 7/2000 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the
new revenue center fields was that data would be populated on claims with dates of service 7/2000 and forward. Data has been found in claims with dates of service prior to 7/2000 because the Standard Systems have processed any claim coming in 7/2000 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

VALUES D, U and T REPRESENT THE FOLLOWING:

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

**LABEL:** Revenue Center (Medicare) Provider Payment Amount

**DESCRIPTION:** The amount Medicare paid for the services reported on the revenue center record.

This field is rarely populated for Part A claims due to per-diem or DRG payments; the claim payment amounts should be used instead.

For Hospital outpatient services (also called Institutional outpatient claims, which consist of claim type [variable called NCH_CLM_TYPE_CD] = 40), this variable can be summed across all revenue center lines for the claim to obtain the total Medicare claim payment amount.

**SHORT NAME:** RPRVDPMT

**LONG NAME:** REV_CNTR_PRVDR_PMT_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

Additional information regarding claim versus revenue-line level payments can be found in a CCW Technical Guidance document entitled: "Getting Started with Medicare Administrative Data."
REV_CNTR_PTNT_RSPNSBLTY_PMT

LABEL: Revenue Center Patient Responsibility Payment Amount

DESCRIPTION: The amount paid by the beneficiary to the provider for the line-item service.

SHORT NAME: PTNTRESP

LONG NAME: REV_CNTR_PTNT_RSPNSBLTY_PMT

TYPE: NUM

LENGTH: 12

SOURCE: NCH

VALUES: XXX.XX

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.
**REV_CNTR_RATE_AMT**

**LABEL:** Revenue Center Rate Amount

**DESCRIPTION:** Charges relating to unit cost associated with the revenue center code.

**SHORT NAME:** REV_RATE

**LONG NAME:** REV_CNTR_RATE_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment.

In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

Exception (encounter data only): If plan (e.g., MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.
**REV_CNTR_RDCD_COINSRNC_AMT**

**LABEL:** Revenue Center Reduced Coinsurance Amount

**DESCRIPTION:** For all services subject to outpatient prospective payment system (PPS or OPPS), the amount of coinsurance applicable to the line for a particular service (as indicated by the HCPCS code) for which the provider has elected to reduce the coinsurance amount.

**SHORT NAME:** RDCDCOIN

**LONG NAME:** REV_CNTR_RDCD_COINSRNC_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** This field is populated for those claims that are required to process through outpatient PPS PRICER software. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals [CAH]); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS.

These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/2002 and forward.

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

**LABEL:** Revenue Center Representative Payee (RP) Indicator Code

**DESCRIPTION:** Revenue Center Representative Payee (RP) Indicator Code

**SHORT NAME:** REV_CNTR_RP_IND_CD

**LONG NAME:** REV_CNTR_RP_IND_CD

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:** R = bypass representative payee

**COMMENT:** This field is used to designate by-passing of the prior authorization processing for claims with a representative payee when an 'R' is present in the field.

This field was new in April 2016.
**REV_CNTR_STUS_IND_CD**

**LABEL:** Revenue Center Status Indicator Code

**DESCRIPTION:** This variable indicates how the service listed on the revenue center record was priced for payment purposes.

The revenue center status indicator code is most useful with outpatient hospital claims, where multiple methods may be used to determine the payment amount for the various revenue center records on the claim (for example, some lines may be bundled into an APC and paid under the outpatient PPS, while other lines may be paid under other fee schedules).

**SHORT NAME:** REVSTIND

**LONG NAME:** REV_CNTR_STUS_IND_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- **A** = Services not paid under OPPS; uses a different fee schedule (e.g., ambulance, PT, mammography)
- **B** = Non-allowed item or service for OPPS; may be paid under a different bill type (e.g., CORF)
- **C** = Inpatient procedure (not paid under OPPS)
- **E** = Non-allowed item or service (not paid by OPPS or any other Medicare payment system)
- **E1** = Non-allowed item or service — not paid by Medicare when submitted on outpatient claims (any outpatient bill type)
- **E2** = Non-allowed item or service for which pricing information and claims data is not available — not paid by Medicare when submitted on outpatient claims (any outpatient bill type)
- **F** = Corneal tissue acquisition, certain CRNA services and Hepatitis B vaccinations
- **G** = Drug/biological pass-through (separate APC includes this pass-through amount)
- **H** = Device pass-through (separate cost-based pass-through payment, not subject to coinsurance)
- **J** = New drug or new biological pass-through
- **J1** = Primary service and all adjunctive services on the claim (comprehensive APC; eff. 01/2015)
- **J2** = Hospital Part B services that may be paid through a comprehensive APC — Paid under OPPS; Addendum B displays APC assignments when services are separately payable
K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources (paid under OPPS; separate APC payment)

L = Flu/PPV vaccines not paid under OPPS

M = Service not billable to fiscal intermediary [now a MAC] (not paid under OPPS)

N = Packaged incidental service (no separate APC payment)

P = Paid partial hospitalization per diem APC payment

Q1 = Separate payment made; OPPS — APC (eff. 2009)

Q2 = No separate payment made; OPPS — APC were packaged into payment for other services (eff. 2009)

Q3 = May be paid through a composite APC-based on composite-specific criteria or separately through single code APCs when the criteria are not met (eff. 2009)

Q4 = Conditionally packaged laboratory tests Paid under OPPS or CLFS

R = Blood products; Paid under OPPS; separate APC payment

S = Significant procedure not subject to multiple procedure discounting

T = Significant procedure subject to multiple procedure discounting

U = Brachytherapy

V = Medical visit to clinic or emergency department

W = Invalid HCPCS or invalid revenue code with blank HCPCS (terminated)

X = Ancillary service (terminated)

Y = Non-implantable DME (e.g., therapeutic shoes; not paid under OPPS — bill to DMERC)

Z = Valid revenue with blank HCPCS and no other SI assigned (terminated)

COMMENT: This 2-byte indicator was added 10/2005 due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

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

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.
**REV_CNTR_RA_RMRK_CD**

**LABEL:** Revenue Center Remittance Advice Remark Code

**DESCRIPTION:** Claim Remittance Advice Remark Code used to provide an additional explanation for an adjustment already described by a claim adjustment reason code (CARC) for a claim or claim line. It is also used to communicate information about remittance processing. This field is currently only populated for Direct Contracting (DC), Comprehensive Kidney Care Contracting (CKCC) and Kidney Care First (KCF) model claims.

**SHORT NAME:** REV_CNTR_RA_RMRK_CD

**LONG NAME:** REV_CNTR_RA_RMRK_CD

**TYPE:** CHAR

**LENGTH:** 5

**SOURCE:** NCH

**VALUES:** N83 = No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

**COMMENT:** This code set is an external code set maintained by X12 ([www.x12.org/codes](http://www.x12.org/codes)). This field is not populated prior to 2021.
**REV_CNTR_THRPY_RDCTN_AMT**

**LABEL:** Revenue Center Therapy Reduction Amount

**DESCRIPTION:** This line level field is used to represent the 15% reduction amount for physical therapy assistant (PTA) and occupational therapy assistant (OTA) services when modifiers CO or CQ are present.

**SHORT NAME:** REV_CNTR_THRPY_RDCTN_AMT

**LONG NAME:** REV_CNTR_THRPY_RDCTN_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** X.XX

**COMMENT:** Applies to types of bill (TOB)s; 13x, 22x, 23x, 34x, 74x, and 75x. This only appears on outpatient claims. This field is not populated prior to 2021.

The TOB is the concatenation of two variables:

Facility type (CLM_FAC_TYPE_CD)

Service classification type (CLM_SRVC_CLSFCTN_TYPE_CD).

Effective January 3, 2023, this field will include the Rural Emergency Hospital (REH) 5% payment increase. Applies to claims processed by the outpatient prospective payment system (OPPS), identified by provider type of ‘24K’, CLM_OP_PPS_IND = 2, and TOBs 13X and 14X.
**REV_CNTR_TOT_CHRG_AMT**

**LABEL:** Revenue Center Total Charge Amount

**DESCRIPTION:** The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.

**SHORT NAME:** REV_CHRG

**LONG NAME:** REV_CNTR_TOT_CHRG_AMT

**TYPE:** NUM

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** XXX.XX

**COMMENT:** For accommodation revenue center total charges must equal the rate times units (days).

**EXCEPTIONS:**

1. For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (i.e., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

2. For SNF PPS (non-demo claims), when revenue center code = '0022', the total charges will be zero.

3. For home health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

4. For home health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

5. For inpatient Rehabilitation Facility (IRF) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X–021X), total charges must equal the rate times the units.

6. For encounter data, if the plan (e.g., MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days).
**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.

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_UNIT

**LONG NAME:** REV_CNTR_UNIT_CNT

**TYPE:** NUM

**LENGTH:** 8

**SOURCE:** NCH

**VALUES:** —

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

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**RFR_PHYSN_NPI**

**LABEL:** Claim Referring Physician NPI Number

**DESCRIPTION:** The national provider identifier (NPI) number assigned to uniquely identify the referring physician.

**SHORT NAME:** RFR_PHYSN_NPI*

**LONG NAME:** RFR_PHYSN_NPI

**TYPE:** CHAR

**LENGTH:** 12

**SOURCE:** NCH

**VALUES:** —

**COMMENT:** * The short SAS name is RFR_NPI in the Carrier and DME files

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

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### RFR_PHYSN_SPCLTY_CD

**LABEL:** Claim Referring Physician Specialty Code  

**DESCRIPTION:** The code used to identify the CMS specialty code of the referring physician/practitioner.  

**SHORT NAME:** RFR_PHYSN_SPCLTY_CD  

**LONG NAME:** RFR_PHYSN_SPCLTY_CD  

**TYPE:** CHAR  

**LENGTH:** 2  

**SOURCE:** NCH  

**VALUES:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Carrier wide</td>
</tr>
<tr>
<td>01</td>
<td>General practice</td>
</tr>
<tr>
<td>02</td>
<td>General surgery</td>
</tr>
<tr>
<td>03</td>
<td>Allergy/immunology</td>
</tr>
<tr>
<td>04</td>
<td>Otolaryngology</td>
</tr>
<tr>
<td>05</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>06</td>
<td>Cardiology</td>
</tr>
<tr>
<td>07</td>
<td>Dermatology</td>
</tr>
<tr>
<td>08</td>
<td>Family practice</td>
</tr>
<tr>
<td>09</td>
<td>Interventional Pain Management (IPM) (eff. 4/1/2003)</td>
</tr>
<tr>
<td>10</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>11</td>
<td>Internal medicine</td>
</tr>
<tr>
<td>12</td>
<td>Osteopathic manipulative medicine</td>
</tr>
<tr>
<td>13</td>
<td>Neurology</td>
</tr>
<tr>
<td>14</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>15</td>
<td>Speech/language pathologist in private practice</td>
</tr>
<tr>
<td>16</td>
<td>Obstetrics/gynecology</td>
</tr>
<tr>
<td>17</td>
<td>Hospice and Palliative Care</td>
</tr>
<tr>
<td>18</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>19</td>
<td>Oral surgery (dentists only)</td>
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<tr>
<td>20</td>
<td>Orthopedic surgery</td>
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<td>Cardiac Electrophysiology</td>
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<td>Pathology</td>
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<td>Sports medicine</td>
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<tr>
<td>24</td>
<td>Plastic and reconstructive surgery</td>
</tr>
<tr>
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<td>Physical medicine and rehabilitation</td>
</tr>
<tr>
<td>26</td>
<td>Psychiatry</td>
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<tr>
<td>27</td>
<td>Geriatric Psychiatry</td>
</tr>
<tr>
<td>28</td>
<td>Colorectal surgery (formerly proctology)</td>
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<tr>
<td>29</td>
<td>Pulmonary disease</td>
</tr>
<tr>
<td>30</td>
<td>Diagnostic radiology</td>
</tr>
<tr>
<td>31</td>
<td>Intensive cardiac rehabilitation</td>
</tr>
<tr>
<td>32</td>
<td>Anesthesiologist Assistant (eff. 4/1/2003 — previously grouped with Certified Registered Nurse Anesthetists (CRNA))</td>
</tr>
<tr>
<td>33</td>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>34</td>
<td>Urology</td>
</tr>
<tr>
<td>35</td>
<td>Chiropractic</td>
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<td>36</td>
<td>Nuclear medicine</td>
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<td>Nephrology</td>
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<td>40</td>
<td>Hand surgery</td>
</tr>
<tr>
<td>41</td>
<td>Optometry</td>
</tr>
<tr>
<td>42</td>
<td>Certified nurse midwife</td>
</tr>
<tr>
<td>43</td>
<td>Certified Registered Nurse Anesthetist (CRNA) (Anesthesiologist Assistants were removed from this specialty 4/1/2003)</td>
</tr>
<tr>
<td>44</td>
<td>Infectious disease</td>
</tr>
<tr>
<td>45</td>
<td>Mammography screening center</td>
</tr>
<tr>
<td>46</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>47</td>
<td>Independent Diagnostic Testing Facility (IDTF)</td>
</tr>
<tr>
<td>48</td>
<td>Podiatry</td>
</tr>
<tr>
<td>49</td>
<td>Ambulatory surgical center (formerly miscellaneous)</td>
</tr>
<tr>
<td>50</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>51</td>
<td>Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>52</td>
<td>Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>53</td>
<td>Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>54</td>
<td>Medical supply company for DMERC (and not included in 51–53)</td>
</tr>
<tr>
<td>55</td>
<td>Individual certified orthotic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>56</td>
<td>Individual certified prosthetic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>57</td>
<td>Individual certified prosthetic-orthotic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>58</td>
<td>Medical supply company with registered pharmacist</td>
</tr>
<tr>
<td>59</td>
<td>Ambulance service (private)</td>
</tr>
<tr>
<td>60</td>
<td>Public health or welfare agencies (federal, state, and local)</td>
</tr>
<tr>
<td>61</td>
<td>Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)</td>
</tr>
<tr>
<td>62</td>
<td>Psychologist (billing independently)</td>
</tr>
<tr>
<td>63</td>
<td>Portable X-ray supplier (billing independently)</td>
</tr>
<tr>
<td>64</td>
<td>Audiologist (billing independently)</td>
</tr>
<tr>
<td>65</td>
<td>Physical therapist in private practice</td>
</tr>
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A4 = Home health agency (DMERCs only)
A5 = Pharmacy (DMERC)
A6 = Medical supply company with respiratory therapist (DMERCs only)
A7 = Department store (DMERC)
A8 = Grocery store (DMERC)
A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital-based facilities, eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/2007)
B2 = Pedorthic Personnel (eff. 10/2/2007)
B3 = Medical Supply Company with pedorthic personnel (eff. 10/2/2007)
B4 = Does not meet definition of health care provider (e.g., Rehabilitation agency, organ procurement organizations, histocompatibility labs) (eff. 10/2/2007)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized flu
C2 = Indirect payment procedure
C3 = Interventional cardiology
C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery (MDS) (eff. October 1, 2020)

COMMENT: —
RFR_PHYSN_UPIN

LABEL: Carrier/DMERC Claim Ordering Physician UPIN Number

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

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

SHORT NAME: RFR_UPIN

LONG NAME: RFR_PHYSN_UPIN

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: —
<table>
<thead>
<tr>
<th><strong>RLT_COND_CD_SEQ</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong> Claim Related Condition Code Sequence</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> The sequence number of the claim related condition code (variable called CLM_RLT_COND_CD).</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong> RLTCNDSQ</td>
</tr>
<tr>
<td><strong>LONG NAME:</strong> RL_T_COND_CD_SEQ</td>
</tr>
<tr>
<td><strong>TYPE:</strong> CHAR</td>
</tr>
<tr>
<td><strong>LENGTH:</strong> 3</td>
</tr>
<tr>
<td><strong>SOURCE:</strong> CCW</td>
</tr>
<tr>
<td><strong>VALUES:</strong> —</td>
</tr>
<tr>
<td><strong>COMMENT:</strong> —</td>
</tr>
</tbody>
</table>
**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:** RLTOCRSEQ  
**LONG NAME:** RLT_OCRNC_CD_SEQ  
**TYPE:** CHAR  
**LENGTH:** 3  
**SOURCE:** CCW  
**VALUES:** —  
**COMMENT:** —
**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:** RLTPNSQ

**LONG NAME:** RLT_SPAN_CD_SEQ

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** CCW

**VALUES:** –

**COMMENT:** –

[^ Back to TOC ^]
**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:** RLTVALSQ  
**LONG NAME:** RLT_VAL_CD_SEQ  
**TYPE:** CHAR  
**LENGTH:** 3  
**SOURCE:** CCW  
**VALUES:** —  
**COMMENT:** —
RNDRNG_PHYSN_NPI

LABEL: Rendering Physician NPI

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

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

SHORT NAME: RNDRNG_PHYSN_NPI

LONG NAME: RNDRNG_PHYSN_NPI

TYPE: CHAR

LENGTH: 12

SOURCE: NCH

VALUES: —

COMMENT: This field appears on both the revenue center and base claim files.

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

^ Back to TOC ^
**RNDRNG_PHYSN_SPCLTY_CD**

**LABEL:** Claim or Revenue Center Rendering Physician Specialty Code

**DESCRIPTION:** The code used to identify the CMS specialty code of the rendering physician/practitioner.

**SHORT NAME:** RNDRNG_PHYSN_SPCLTY_CD

**LONG NAME:** RNDRNG_PHYSN_SPCLTY_CD

**TYPE:** CHAR

**LENGTH:** 2

**SOURCE:** NCH

**VALUES:**

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Interventional Pain Management (IPM) (eff. 4/1/2003)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative medicine
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Speech/language pathologist in private practice
- 16 = Obstetrics/gynecology
- 17 = Hospice and Palliative Care
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Cardiac Electrophysiology
- 22 = Pathology
- 23 = Sports medicine
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = Geriatric Psychiatry
- 28 = Colorectal surgery (formerly proctology)
- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Intensive cardiac rehabilitation
- 32 = Anesthesiologist Assistant (eff. 4/1/2003 — previously grouped with Certified Registered Nurse G)
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometry
- 42 = Certified nurse midwife
- 43 = Certified Registered Nurse Anesthetist (CRNA)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology
- 47 = Independent Diagnostic Testing Facility (IDTF)
- 48 = Podiatry
- 49 = Ambulatory surgical center (formerly miscellaneous)
- 50 = Nurse practitioner
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>52</td>
<td>Medical supply company with certified prosthetist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>53</td>
<td>Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)</td>
</tr>
<tr>
<td>54</td>
<td>Medical supply company for DMERC (and not included in 51–53)</td>
</tr>
<tr>
<td>55</td>
<td>Individual certified orthotic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>56</td>
<td>Individual certified prosthetic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>57</td>
<td>Individual certified prosthetic-orthotic personnel certified by an accrediting organization</td>
</tr>
<tr>
<td>58</td>
<td>Medical supply company with registered pharmacist</td>
</tr>
<tr>
<td>59</td>
<td>Ambulance service (private)</td>
</tr>
<tr>
<td>60</td>
<td>Public health or welfare agencies (federal, state, and local)</td>
</tr>
<tr>
<td>61</td>
<td>Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)</td>
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<tr>
<td>62</td>
<td>Psychologist (billing independently)</td>
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<td>63</td>
<td>Portable X-ray supplier (billing independently)</td>
</tr>
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C1 = Centralized flu
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C5 = Dentist (eff. 7/2016)
C6 = Hospitalist
C7 = Advanced heart failure and transplant cardiology
C8 = Medical toxicology
C9 = Hematopoietic cell transplantation and cellular therapy
D3 = Medical genetics and genomics
D4 = Undersea and Hyperbaric Medicine
D5 = Opioid Treatment Program (eff. 1/2020)
D7 = Micrographic Dermatologic Surgery (MDS) (eff. October 1, 2020)

COMMENT: This field appears on both the revenue center and base claim files.
### RNDRNG_PHYSN_UPIN

**LABEL:** Revenue Center Rendering Physician UPIN  

**DESCRIPTION:** This variable is the unique physician identification number (UPIN) for the physician who rendered the services on the revenue center record.  

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

**SHORT NAME:** RNDRNG_PHYSN_UPIN  

**LONG NAME:** RNDRNG_PHYSN_UPIN  

**TYPE:** CHAR  

**LENGTH:** 12  

**SOURCE:** NCH  

**VALUES:** —  

**COMMENT:** —
**RR_BRD_EXCLSN_IND_SW**

**LABEL:** Railroad Board Exclusion Indicator Switch

**DESCRIPTION:** This field indicates whether Railroad Board (RRB) beneficiary claim should be excluded from Prior Authorization processing.

**SHORT NAME:** RR_BRD_EXCLSN_IND_SW

**LONG NAME:** RR_BRD_EXCLSN_IND_SW

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**
- Y = Yes (exclude RRB beneficiary from PA)
- Null/missing = Subject RRB beneficiary services to prior authorization

**COMMENT:** This field informs the SSMs and CWF if the RRB beneficiary claim should either be included or excluded from Prior Authorization (PA) processing. Ex: If the field is valued “Y”, and it is RRB beneficiary claim, it will be excluded from PA processing.

This field was new in April 2019.
RSN_VISIT_CD1

RSN_VISIT_CD2

RSN_VISIT_CD3

LABEL:  Reason for Visit Diagnosis Code

DESCRIPTION:  The diagnosis code used to identify the patient's reason for the Hospital outpatient visit.

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:  NCH

VALUES:  —

COMMENT:  Prior to Version ‘J,’ this field was: CLM_ADMTG_DGNS_CD.

With Version ‘J,’ the name has changed and there can be up to 3 occurrences of this group.

On October 1, 2015, the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred.
RSN_VISIT_VRSN_CD1
RSN_VISIT_VRSN_CD2
RSN_VISIT_VRSN_CD3

**LABEL:** Reason for Visit Diagnosis Code Version Code (ICD-9 or ICD-10)

**DESCRIPTION:** The code used to indicate if the reason for visit diagnosis code is ICD-9 or ICD-10.

**SHORT NAME:** RSN_VISIT_VRSN_CD1
  RSN_VISIT_VRSN_CD1
  RSN_VISIT_VRSN_CD1

**LONG NAME:** RSN_VISIT_VRSN_CD1
  RSN_VISIT_VRSN_CD1
  RSN_VISIT_VRSN_CD1

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

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

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

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

This code is associated with the diagnosis code identified in the corresponding RSN_VISIT_CD#.
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Label</th>
<th>Description</th>
<th>Short Name</th>
<th>Long Name</th>
<th>Type</th>
<th>Length</th>
<th>Source</th>
<th>Values</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRVC_LOC_NPI_NUM</td>
<td>Claim Service Location NPI Number</td>
<td>The National Provider Identifier (NPI) of the location where the services were provided.</td>
<td>SRVC_LOC_NPI_NUM</td>
<td>SRVC_LOC_NPI_NUM</td>
<td>CHAR</td>
<td>22</td>
<td>NCH</td>
<td>—</td>
<td>This field was new in January 2014. It is null/missing for all years prior.</td>
</tr>
</tbody>
</table>
TAX_NUM

LABEL: Line Provider Tax Number

DESCRIPTION: The federal taxpayer identification number (TIN) that identifies the physician/practice/supplier to whom payment is made for the line-item service on the noninstitutional claim. This number may be an employer identification number (EIN) or social security number (SSN).

SHORT NAME: TAX_NUM

LONG NAME: TAX_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: For DME claims, all 10 digits are populated. The first 9 digits represent the EIN or SSN, and the final (rightmost) tenth digit indicates the type of provider ID that is used (reference the DMERC_LINE_SUPPLR_TYPE_CD for these values). For all other claim types, only 9 digits of the field are populated.

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**THRPY_CAP_IND_CD1**
**THRPY_CAP_IND_CD2**
**THRPY_CAP_IND_CD3**
**THRPY_CAP_IND_CD4**
**THRPY_CAP_IND_CD5**

**LABEL:** Therapy Cap Indicator Code

**DESCRIPTION:** The field used to identify whether the claim line (or revenue center) is subject to a therapy cap.

**SHORT NAME:** THRPY_CAP_IND_CD1
THRPY_CAP_IND_CD2
THRPY_CAP_IND_CD3
THRPY_CAP_IND_CD4
THRPY_CAP_IND_CD5

**LONG NAME:** THRPY_CAP_IND_CD1
THRPY_CAP_IND_CD2
THRPY_CAP_IND_CD3
THRPY_CAP_IND_CD4
THRPY_CAP_IND_CD5

**TYPE:** CHAR

**LENGTH:** 1

**SOURCE:** NCH

**VALUES:**

A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator is used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). **NOTE:** Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The $3,700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

**COMMENT:** This field appears on the revenue center / line files.

In the Carrier line file, there are up to five indicators for the therapy cap — reference variables called THRPY_CAP_IND_CD1–THRPY_CAP_IND_CD5. In institutional revenue center files (inpatient, SNF,
hospice, home health, and outpatient), there are two occurrences of this field (THRPY_CAP_IND_CD1–THRPY_CAP_IND_CD2).

Details regarding the therapy cap can be found on the CMS website, under the Medicare therapy services web page (reference, for example: https://www.cms.gov/Medicare/Billing/TherapyServices/index.html).
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
<th>Short Name</th>
<th>Long Name</th>
<th>Type</th>
<th>Length</th>
<th>Source</th>
<th>Values</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRNSTNL_DRUG_ADD_ON_PYMT_AMT</td>
<td>This field houses the amount for the Transitional Drug Add-On Payment Adjustment (TDAPA) for ESRD claims (72X) with injectable, intravenous, and oral calcimimetics when reported with an AX modifier. These services qualify for an add-on payment from the ESRD Pricer.</td>
<td>TRNSTNL_DRUG_ADD_ON_PYMT_AMT</td>
<td>TRNSTNL_DRUG_ADD_ON_PYMT_AMT</td>
<td>NUM</td>
<td>12</td>
<td>NCH</td>
<td>XXX.XX</td>
<td>This field is new in 2018 and applies only to Hospital outpatient claims.</td>
</tr>
</tbody>
</table>