Chronic Conditions Warehouse

CODEBOOK:
Master Beneficiary Summary File (MBSF)
30 CCW Chronic Conditions (CHRONIC) File

MARCH 2022 | VERSION 1.0

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Revision Log

Date	Changed by	Revisions	Version
March 2022	A. Arens A. Sisco K. Schneider	Initial release of codebook	1.0

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the Medicare Beneficiary Summary File (MBSF) — 30 CCW Chronic Conditions (CHRONIC) research files. We have included several ways for users to quickly find the information they need:

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

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

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

Table of Contents

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

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Variable Details

This section of the codebook contains one entry for each variable in the Medicare Beneficiary Summary File (MBSF) 30 CCW Chronic Conditions (CHRONIC) files. Each entry contains variable details to facilitate understanding and use of the variables.

ALZH

LABEL: Alzheimer's Disease End-of-Year Indicator

DESCRIPTION: This code specifies whether the beneficiary met the Chronic Conditions Warehouse (CCW) algorithm criteria for Alzheimer's disease as of the end of the calendar year.

SHORT NAME: —

LONG NAME: ALZH

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For Alzheimer's disease, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with an Alzheimer's disease code in any position during the two-year reference period.

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

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ALZH_EVER

LABEL: Date that beneficiary first met claims criteria for the Alzheimer's disease indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) Alzheimer's disease indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: ALZH_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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AMI

LABEL: Acute Myocardial Infarction End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for an acute myocardial infarction (AMI; heart attack) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: AMI

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For AMI, beneficiaries must have at least one inpatient claim with an AMI diagnosis code in any position during the one-year reference period.

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

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AMI_EVER

LABEL: Date that beneficiary first met claims criteria for the AMI indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) acute myocardial infarction (AMI; heart attack) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: AMI_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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ANEMIA

LABEL: Anemia End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for anemia as of the end of the calendar year.

SHORT NAME: —

LONG NAME: ANEMIA

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For anemia, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with an anemia code in any position during the two-year reference period.

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

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ANEMIA_EVER

LABEL: Date that beneficiary first met claims criteria for the anemia indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) anemia indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: ANEMIA_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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ASTHMA

LABEL: Asthma End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for asthma as of the end of the calendar year.

SHORT NAME: —

LONG NAME: ASTHMA

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For asthma, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with an asthma code in any position during the two-year reference period.

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

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ASTHMA_EVER

LABEL: Date that beneficiary first met claims criteria for the asthma indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) asthma indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: ASTHMA_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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ATRIAL_FIB

LABEL: Atrial Fibrillation and Flutter End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for atrial fibrillation and flutter as of the end of the calendar year.

SHORT NAME: —

LONG NAME: ATRIAL_FIB

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For atrial fibrillation and flutter, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with an atrial fibrillation or flutter code in any position during the two-year reference period.

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

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ATRIAL_FIB_EVER

LABEL: Date that beneficiary first met claims criteria for the atrial fibrillation and flutter indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) atrial fibrillation and flutter indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: ATRIAL_FIB_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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BENE_ENROLLMT_REF_YR

LABEL: Reference Year

DESCRIPTION: This field indicates the reference year of the enrollment data.

SHORT NAME: —

LONG NAME: BENE_ENROLLMT_REF_YR

TYPE: NUM

LENGTH: 4

SOURCE: CMS Enrollment Database (EDB)

VALUES: 2017–current data year

COMMENT: The data files are partitioned into calendar year files.

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BENE_ID

LABEL: Encrypted CCW Beneficiary ID

DESCRIPTION: The unique CCW identifier for a beneficiary.

The Chronic Conditions Warehouse (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, Medicaid T-MSIS claims, MDS assessment data).

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

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

SHORT NAME: —

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW

VALUES: —

COMMENT: —

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BPH

LABEL: Benign Prostatic Hyperplasia (BPH) End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for benign prostatic hyperplasia as of the end of the calendar year.

SHORT NAME: —

LONG NAME: BPH

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For benign prostatic hyperplasia, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a benign prostatic hyperplasia code in any position during the two-year reference period. If any qualifying claim also has a diagnosis code for benign neoplasm (of the prostate), then it is excluded from this indicator. Refer to the coding algorithm for details.

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

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BPH_EVER

LABEL: Date that beneficiary first met claims criteria for the benign prostatic hyperplasia (BPH) indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) benign prostatic hyperplasia indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: BPH_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CANCER_BREAST

LABEL: Breast Cancer End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for breast cancer (female or male) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CANCER_BREAST

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For breast cancer, beneficiaries must have at least one inpatient or skilled nursing facility (SNF) claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a breast cancer code in any position during the two-year reference period.

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

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CANCER_BREAST_EVER

LABEL: Date that beneficiary first met claims criteria for female/male breast cancer indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) breast cancer (female or male) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CANCER_BREAST_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CANCER_COLORECTAL

LABEL: Colorectal Cancer End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for colorectal cancer as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CANCER_COLORECTAL

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For colorectal cancer, beneficiaries must have at least one inpatient or skilled nursing facility (SNF) claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a colorectal cancer code in any position during the two-year reference period.

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

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CANCER_COLORECTAL_EVER

LABEL: Date that beneficiary first met claims criteria for the colorectal cancer indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) colorectal cancer indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CANCER_COLORECTAL_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CANCER_ENDOMETRIAL

LABEL: Endometrial Cancer End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for endometrial cancer as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CANCER_ENDOMETRIAL

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For endometrial cancer, beneficiaries must have at least one inpatient or skilled nursing facility (SNF) claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with an endometrial cancer code in any position during the two-year reference period.

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

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CANCER_ENDOMETRIAL_EVER

LABEL: Date that beneficiary first met claims criteria for the endometrial cancer indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) endometrial cancer indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CANCER_ENDOMETRIAL_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CANCER_LUNG

LABEL: Lung Cancer End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for lung cancer as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CANCER_LUNG

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For lung cancer, beneficiaries must have at least one inpatient or skilled nursing facility (SNF) claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a lung cancer code in any position during the two-year reference period.

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

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CANCER_LUNG_EVER

LABEL: Date that beneficiary first met claims criteria for the lung cancer indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) lung cancer indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CANCER_LUNG_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CANCER_PROSTATE

LABEL: Prostate Cancer End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for prostate cancer as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CANCER_PROSTATE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For prostate cancer, beneficiaries must have at least one inpatient or skilled nursing facility (SNF) claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a prostate cancer code in any position during the two-year reference period.

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

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CANCER_PROSTATE_EVER

LABEL: Date that beneficiary first met claims criteria for the prostate cancer indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) prostate cancer indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CANCER_PROSTATE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CANCER_UROLOGIC

LABEL: Urologic Cancer (kidney, renal pelvis, and ureter) End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for urologic cancer (kidney, renal pelvis, and ureter) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CANCER_UROLOGIC

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For urologic cancer, beneficiaries must have at least one inpatient or skilled nursing facility (SNF) claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a urologic cancer code in any position during the two-year reference period.

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

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CANCER_UROLOGIC_EVER

LABEL: Date that beneficiary first met claims criteria for the urologic cancer (kidney, renal pelvis, and ureter) indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) urologic cancer (kidney, renal pelvis, and ureter) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CANCER_UROLOGIC_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CATARACT

LABEL: Cataract End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for a cataract as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CATARACT

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For a cataract, beneficiaries must have at least one Part B (institutional or non-institutional) claim with a cataract code in any position during the one-year reference period.

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

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CATARACT_EVER

LABEL: Date that beneficiary first met claims criteria for the cataract indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) cataract indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CATARACT_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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CHRONICKIDNEY

LABEL: Chronic Kidney Disease End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for chronic kidney disease (CKD) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: CHRONICKIDNEY

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For chronic kidney disease, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a chronic kidney disease code in any position during the two-year reference period.

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

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CHRONICKIDNEY_EVER

LABEL: Date that beneficiary first met claims criteria for the chronic kidney disease indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) chronic kidney disease indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: CHRONICKIDNEY_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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COPD

LABEL: Chronic Obstructive Pulmonary Disease End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for chronic obstructive pulmonary disease (COPD) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: COPD

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For COPD, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a COPD code in any position during the two-year reference period.

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

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COPD_EVER

LABEL: Date that beneficiary first met claims criteria for the chronic obstructive pulmonary disease indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) chronic obstructive pulmonary disease (COPD) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: COPD_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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DEPRESSION

LABEL: Depression, Bipolar, or Other Depressive Mood Disorders End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for depression, bipolar, or other depressive mood disorders as of the end of the calendar year.

SHORT NAME: —

LONG NAME: DEPRESSION

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For depression, bipolar, or other depressive mood disorders, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a depression, bipolar, or other depressive mood disorders code in any position during the two-year reference period.

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

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DEPRESSION_EVER

LABEL: Date that beneficiary first met claims criteria for the depression, bipolar, or other depressive mood disorders indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) depression, bipolar, or other depressive mood disorders indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: DEPRESSION_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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DIABETES

LABEL: Diabetes End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for diabetes as of the end of the calendar year.

SHORT NAME: —

LONG NAME: DIABETES

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For diabetes, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a diabetes code in any position during the two-year reference period.

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

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DIABETES_EVER

LABEL: Date that beneficiary first met claims criteria for the diabetes indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) diabetes indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: DIABETES_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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GLAUCOMA

LABEL: Glaucoma End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for glaucoma as of the end of the calendar year.

SHORT NAME: —

LONG NAME: GLAUCOMA

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For glaucoma, beneficiaries must have at least one Part B (institutional or non-institutional) claim with a glaucoma code in any position during the two-year reference period.

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

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GLAUCOMA_EVER

LABEL: Date that beneficiary first met claims criteria for the glaucoma indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) glaucoma indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: GLAUCOMA_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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HF

LABEL: Heart Failure and Non-Ischemic Heart Disease End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for heart failure (HF) and non-ischemic heart disease as of the end of the calendar year.

SHORT NAME: —

LONG NAME: HF

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For heart failure and non-ischemic heart disease, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a heart failure and non-ischemic heart disease code in any position during the two-year reference period.

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

^ Back to TOC ^

HF_EVER

LABEL: Date that beneficiary first met claims criteria for the heart failure and non-ischemic heart disease indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) heart failure and non-ischemic heart disease indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: HF_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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HIP_FRACTURE

LABEL: Hip/Pelvic Fracture End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for a hip/pelvic fracture as of the end of the calendar year.

SHORT NAME: —

LONG NAME: HIP_FRACTURE

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For hip/pelvic fractures, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or Part B (institutional or non-institutional) claim with a hip/pelvic fracture code in any position during the one-year reference period.

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

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HIP_FRACTURE_EVER

LABEL: Date that beneficiary first met claims criteria for the hip/pelvic fracture indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) hip/pelvic fracture indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: HIP_FRACTURE_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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HLP

LABEL: Hyperlipidemia End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for hyperlipidemia (HLP) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: HLP

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For hyperlipidemia, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a hyperlipidemia code in any position during the two-year reference period.

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

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HLP_EVER

LABEL: Date that beneficiary first met claims criteria for the hyperlipidemia indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) hyperlipidemia (HLP) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: HLP_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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HTN

LABEL: Hypertension End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for hypertension (HTN; high blood pressure) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: HTN

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For hypertension, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a hypertension code in any position during the two-year reference period.

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

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HTN_EVER

LABEL: Date that beneficiary first met claims criteria for the hypertension indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) hypertension (HTN; high blood pressure) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: HTN_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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HYPTHYRD

LABEL: Hypothyroidism End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for hypothyroidism as of the end of the calendar year.

SHORT NAME: —

LONG NAME: HYPTHYRD

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For hypothyroidism, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a hypothyroidism code in any position during the two-year reference period.

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

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HYPTHYRD_EVER

LABEL: Date that beneficiary first met claims criteria for the hypothyroidism indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) hypothyroidism indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: HYPTHYRD_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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ISCHEMICHEART

LABEL: Ischemic Heart Disease End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for ischemic heart disease (IHD) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: ISCHEMICHEART

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For ischemic heart disease, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with an ischemic heart disease code in any position during the two-year reference period.

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

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ISCHEMICHEART_EVER

LABEL: Date that beneficiary first met claims criteria for the ischemic heart disease indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) ischemic heart disease (IHD) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: ISCHEMICHEART_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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NONALZH_DEMEN

LABEL: Non-Alzheimer's Dementia End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for non-Alzheimer's dementia as of the end of the calendar year.

SHORT NAME: —

LONG NAME: NONALZH_DEMEN

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For non-Alzheimer's dementia, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a non-Alzheimer's dementia code in any position during the two-year reference period.

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

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NONALZH_DEMEN_EVER

LABEL: Date that beneficiary first met claims criteria for the non-Alzheimer's dementia indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) non-Alzheimer's dementia indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: NONALZH_DEMEN_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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OSTEOPOROSIS

LABEL: Osteoporosis With or Without Pathological Fracture End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for osteoporosis with or without pathological fracture as of the end of the calendar year.

SHORT NAME: —

LONG NAME: OSTEOPOROSIS

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For osteoporosis with or without pathological fracture, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with an osteoporosis with or without pathological fracture code in any position during the two-year reference period.

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

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OSTEOPOROSIS_EVER

LABEL: Date that beneficiary first met claims criteria for the osteoporosis with or without pathological fracture indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) osteoporosis with or without pathological fracture indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: OSTEOPOROSIS_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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PNEUMO

LABEL: All Cause Pneumonia End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for all-cause pneumonia as of the end of the calendar year.

SHORT NAME: —

LONG NAME: PNEUMO

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For all-cause pneumonia, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a pneumonia code in any position during the one-year reference period.

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

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PNEUMO_EVER

LABEL: Date that beneficiary first met claims criteria for the all-cause pneumonia indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) all-cause pneumonia indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: PNEUMO_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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PRKNSN

LABEL: Parkinson's Disease and Secondary Parkinsonism End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for Parkinson's disease and secondary parkinsonism as of the end of the calendar year.

SHORT NAME: —

LONG NAME: PRKNSN

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For Parkinson's disease and secondary parkinsonism, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a Parkinson's disease and secondary parkinsonism code in any position during the two-year reference period.

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

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PRKNSN_EVER

LABEL: Date that beneficiary first met claims criteria for the Parkinson's disease and secondary parkinsonism indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) Parkinson's disease and secondary parkinsonism indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: PRKNSN_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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RA_OA

LABEL: Rheumatoid Arthritis/Osteoarthritis End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for rheumatoid arthritis/osteoarthritis as of the end of the calendar year.

SHORT NAME: —

LONG NAME: RA_OA

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For rheumatoid arthritis/osteoarthritis, beneficiaries must have at least one inpatient, skilled nursing facility (SNF), or home health claim, or two Part B (institutional or non-institutional) claims that are at least one day apart, with a rheumatoid arthritis/osteoarthritis code in any position during the two-year reference period.

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

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RA_OA_EVER

LABEL: Date that beneficiary first met claims criteria for the rheumatoid arthritis/osteoarthritis indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) rheumatoid arthritis/osteoarthritis indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: RA_OA_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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STROKE_TIA

LABEL: Stroke/Transient Ischemic Attack End-of-Year Indicator

DESCRIPTION: This variable indicates whether a beneficiary met the Chronic Conditions Warehouse (CCW) criteria for stroke/transient ischemic attack (TIA) as of the end of the calendar year.

SHORT NAME: —

LONG NAME: STROKE_TIA

TYPE: NUM

LENGTH: 1

SOURCE: CCW (derived)

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

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

For stroke/TIA, beneficiaries must have at least one inpatient or Part B (institutional or non-institutional) claim with a stroke/TIA code in any position during the one-year reference period. If any qualifying claim also has a diagnosis code for stroke related to injury or trauma, then it is excluded from this indicator. Refer to the coding algorithm for details.

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

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STROKE_TIA_EVER

LABEL: Date that beneficiary first met claims criteria for the stroke/transient ischemic attack indicator

DESCRIPTION: This variable shows the date when the beneficiary first met the criteria for the Chronic Conditions Warehouse (CCW) stroke/transient ischemic attack (TIA) indicator. The variable will be blank for beneficiaries that have never had the condition.

SHORT NAME: —

LONG NAME: STROKE_TIA_EVER

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

VALUES: —

COMMENT: The earliest possible date for this variable is January 1, 2016, since the algorithm for this condition requires ICD-10 diagnosis codes within the specified lookback period. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after his/her coverage start date (i.e., the COVSTART variable in the Master Beneficiary Summary File [MBSF]).

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