Chronic Conditions Warehouse

CODEBOOK: MedPAR

DECEMBER 2022 | VERSION 4.1

This page intentionally left blank.

Revision Log

Date	Changed by	Revisions	Version
December 2022	K. Schneider	Added 11 new variables: CLNCL_TRIL_SW DRG_GRPR_VRSN_CD EMER_USE_SW EXPNDD_ACS_SW HOSP_AT_HOME_CHRG_AMT HOSP_AT_HOME_FROM_DT HOSP_AT_HOME_THRU_DT NO_PSTV_TEST_SW PPS_PRCR_VRSN_CD PRVDR_BASE_FAC_CCN_NUM PRVDR_FULL_CCN_NUM Updated derivation rules for the following variables: PRVDR_NUM PRVDR_NUM_SPCL_UNIT_CD SEMIPRVT_ROOM_DAY_CNT SEMIPRVT_ROOM_CHRG_AMT Added value and corresponding description for: SRC_IP_ADMSN_CD	4.1
December 2021	S. Pietzsch	Added 11 new variables: LTCH_DPP_ADJSTMT_AMT RC_NDC_1_CD–RC NDC_10_CD Changed DRG_CD variable length from 3 to 4 bytes	4.0
November 2020	K. Schneider	Added six new variables: CELL_GENE_THRPY_PRCDRS_TOT_AMT CELL_THRPY_DRUGS_TOT_AMT CLM_MODEL_REIMBRSMT_AMT GENE_THRPY_DRUGS_TOT_AMT RC_MODEL_REIMBRSMT_AMT VAL_CD_QB_OCM_PYMT_ADJSTMT_AMT	3.0
November 2019	K. Schneider	Added two new variables from 2018 file release	2.0
July 2019	K. Schneider A. Sisco	Created initial document	1.0

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the MedPAR files. Because the files have such a large number of variables, we have included several ways for analysts to quickly find the information they need.

- A complete listing of all variables in the files, in alphabetical order based on their SAS variable names.
- Individual entries for each variable that contain a short description of the variable, the possible values for the variable, and, in many cases, notes that discuss how the variable was constructed and should be used.

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

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

Table of Contents

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

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

Variable Details

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

ACMDTNS_TOT_CHRG_AMT

LABEL: Total Charge for All Accommodations ($)

DESCRIPTION: The total charge amount (rounded to whole dollars) for all accommodations (routine hospital room and board charges for general care, coronary care and/or intensive care units) related to a beneficiary's stay.

SHORT NAME: ACMDTNS

LONG NAME: ACMDTNS_TOT_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is the sum of MEDPAR private room charge amounts, MEDPAR semiprivate room charge amount, MEDPAR ward charge amount, MEDPAR intensive care charge amount, and MEDPAR coronary care charge amount (i.e., the accumulation of the revenue center total charge amounts associated with revenue center codes 0100–0219 from all claim records included in the stay).

^ Back to TOC ^

ACO_ID_NUM

LABEL: Accountable Care Organization (ACO) Identification Number

DESCRIPTION: The field at the claim level to identify the unique identification number assigned to the Accountable Care Organization (ACO).

SHORT NAME: ACO_ID_NUM

LONG NAME: ACO_ID_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the Claim ACO Identification Number (CLM_ACO_ID_NUM) that is present on the first claim record included in the stay. If there is no CLM_ACO_ID_NUM on the 1st claim, then take the first found on any of the other claims that make up the stay.

^ Back to TOC ^

ACTV_XREF_IND

LABEL: MEDPAR Active Cross Reference Indicator

DESCRIPTION: The code indicating whether the claim number originated from a cross-reference.

SHORT NAME: ACTV_XREF_IND

LONG NAME: ACTV_XREF_IND

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: X = Cross-Reference
A = Active

COMMENT: This field is always missing.

^ Back to TOC ^

ADMSN_DAY_CD

LABEL: Code indicating day of week beneficiary was admitted to facility

DESCRIPTION: The code indicating the day of the week on which the beneficiary was admitted to a facility.

SHORT NAME: ADMSNDAY

LONG NAME: ADMSN_DAY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
1 = Sunday
2 = Monday
3 = Tuesday
4 = Wednesday
5 = Thursday
6 = Friday
7 = Saturday

COMMENT: This field is derived from the admission date that is present on the first claim record included in the stay.

^ Back to TOC ^

ADMSN_DEATH_DAY_CNT

LABEL: Days from date admitted to facility to date of death

DESCRIPTION: The count of the number of days from the date the beneficiary was admitted to a facility to the beneficiary's date of death (DOD).

SHORT NAME: DEATHDT

LONG NAME: ADMSN_DEATH_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by counting the number of days between the MEDPAR admission date (the admission date present on the first claim record included in the stay) and MEDPAR beneficiary death date (the death date present on the enrollment database.

^ Back to TOC ^

ADMSN_DT

LABEL: Date beneficiary admitted for Inpatient care or date care started

DESCRIPTION: The date on which the beneficiary was admitted for Inpatient care or the date that care started.

SHORT NAME: ADMSNDT

LONG NAME: ADMSN_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived from the admission date that is present on the first claim record included in the stay.

^ Back to TOC ^

ADMTG_DGNS_CD

LABEL: Initial diagnosis at time of admission

DESCRIPTION: The diagnosis code indicating the beneficiary's initial diagnosis at the time of admission.

SHORT NAME: AD_DGNS

LONG NAME: ADMTG_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the admitting diagnosis code that is present on the last claim record included in the stay.

For ICD-9 diagnosis codes, this is a 3–5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in October 2015, ICD-10 diagnosis codes are used. A variable that indicates the version of the diagnosis code used appears for each occurrence (e.g., ADMTG_DGNS_VRSN_CD).

This diagnosis code may not be confirmed after the patient is evaluated; it may be different than the eventual diagnoses (e.g., as in DGNSCD1–DGNSCD25).

^ Back to TOC ^

ADMTG_DGNS_VRSN_CD

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

DESCRIPTION: Effective with Version 'J', the code used to indicate if the admitting diagnosis code (variable called AD_DGNS) is ICD-9 or ICD-10.

SHORT NAME: ADMTG_DGNS_VRSN_CD

LONG NAME: ADMTG_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null/missing = ICD-9
9 = ICD-9
0 = ICD-10

COMMENT: ICD-10 codes were used starting October 2015. This field was new in 2011.

^ Back to TOC ^

AMBLNC_CHRG_AMT

LABEL: Ambulance Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for ambulance services related to a beneficiary's stay.

SHORT NAME: AMBLNC

LONG NAME: AMBLNC_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 054x from all claim records included in the stay.

^ Back to TOC ^

ANSTHSA_CHRG_AMT

LABEL: Anesthesia Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for anesthesia services provided during the beneficiary's stay.

SHORT NAME: ANSTHSA

LONG NAME: ANSTHSA_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 037X from all claim records included in the stay.

^ Back to TOC ^

BASE_OPRTG_DRG_AMT

LABEL: Base Operating DRG Amount

DESCRIPTION: The sum of the claim base operating DRG amounts reported on the claims that comprise the stay.

SHORT NAME: BASE_OPRTG_DRG_AMT

LONG NAME: BASE_OPRTG_DRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field was new in 2011.

This field is derived by accumulating the Claim Base Operating DRG amount (CLM-BASE-OPRTG-DRG-AMT) that is present on any of the claim records included in the stay (i.e., the sum of the claim base operating DRG amounts reported on the claims that comprise the stay).

The base operating DRG amount used to identify the wage adjusted DRG operating payment plus the new technology add-on payment.

^ Back to TOC ^

BENE_AGE_CNT

LABEL: Age as of Date of Admission

DESCRIPTION: The beneficiary's age in years on the date of admission

SHORT NAME: AGE_CNT

LONG NAME: BENE_AGE_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: X–XXX

COMMENT: This field is derived by subtracting the beneficiary's date of birth from the admission date, using the first claim record for the stay.

The only exception to this formula is if the resulting age is 64, and the Medicare Status Code = 10 (Aged without end-stage renal disease (ESRD) or 11 (Aged with ESRD), the age is changed to 65.

^ Back to TOC ^

BENE_BLOOD_DDCTBL_AMT

LABEL: Beneficiary’s liability for blood deductible for stay ($)

DESCRIPTION: The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the blood deductible for the stay.

SHORT NAME: BLDDEDAM

LONG NAME: BENE_BLOOD_DDCTBL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the beneficiary blood deductible liability amount that is present on any of the claim records included in the stay (i.e., the sum of the blood deductibles reported on the claims that comprise the stay).

^ Back to TOC ^

BENE_DEATH_DT

LABEL: Date beneficiary died

DESCRIPTION: The date the beneficiary died.

SHORT NAME: DEATHDT

LONG NAME: BENE_DEATH_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the beneficiary death date if present on the enrollment database. It is null/missing if there is no date of death.

^ Back to TOC ^

BENE_DEATH_DT_VRFY_CD

LABEL: Death Date Verification Code

DESCRIPTION: The code indicating whether the beneficiary's date of death has been verified the Social Security Administration (SSA) or originated from a claim record.

SHORT NAME: DEATHCD

LONG NAME: BENE_DEATH_DT_VRFY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null = Default
V = Valid death date

COMMENT: This field is derived from the enrollment database's beneficiary source death date code, or from the presence of a claim status code = '20' (expired) on the last claim record included in the stay.

^ Back to TOC ^

BENE_DSCHRG_STUS_CD

LABEL: Code identifying status of patient as of CLM_THRU_DT

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

SHORT NAME: DSCHRGCD

LONG NAME: BENE_DSCHRG_STUS_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
A = Discharged
B = Died
C = Still a patient

COMMENT: This field is derived from the patient discharge status code (i.e., from the NCH variable NCH_PTNT_STUS_CD) that is present on the last claim record for the stay.

^ Back to TOC ^

BENE_ID

LABEL: CCW Encrypted Beneficiary ID Number

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, and MDS assessment data).

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

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

SHORT NAME: BENE_ID

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW (derived)

VALUES: —

COMMENT: —

^ Back to TOC ^

BENE_IDENT_CD

LABEL: BIC reported on first claim included in stay

DESCRIPTION: The MEDPAR Beneficiary Identification Code (BIC) reported on the first claim record included in the stay.

SHORT NAME: BIC

LONG NAME: BENE_IDENT_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
A = Primary claimant
B = Aged wife, age 62 or over (1st claimant)
B1 = Aged husband, age 62 or over (1st claimant)
B2 = Young wife, with a child in her care (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9, CA-CZ = Child (includes minor, student, or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of age 60) (1st claimant)
D5 = Widower (remarried after attainment of age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over (1st claimant)

D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)
DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower) (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)
EK = Surviving divorced father (4th claimant)
EM = Surviving divorced father (5th claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother

F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB
(less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB
(over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
M = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured entitled to HIB under deemed or renal provisions
TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)
TH = MQGE aged spouse (third claimant)
TJ = MQGE aged spouse (fourth claimant)
TK = MQGE aged spouse (fifth claimant)
TL = MQGE aged widow(er) (second claimant)
TM = MQGE aged widow(er) (third claimant)
TN = MQGE aged widow(er) (fourth claimant)
TP = MQGE aged widow(er) (fifth claimant)
TQ = MQGE parent (female)
TR = MQGE young widow(er) (second claimant)
TS = MQGE young widow(er) (third claimant)
TT = MQGE young widow(er) (fourth claimant)
TU = MQGE young widow(er) (fifth claimant)
TV = MQGE disabled widow(er) fifth claimant
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth claimant)
W = Disabled widow, age 50 or over (1st claimant)
W1 = Disabled widower, age 50 or over (1st claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st claimant)
W7 = Disabled surviving divorced wife (2nd claimant)
W8 = Disabled surviving divorced wife (3rd claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th claimant)
WF = Disabled widow (5th claimant)

WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th claimant)
WR = Disabled surviving divorced husband (1st claimant)
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board (RRB):
10 = Retirement - employee or annuitant
11 = Survivor joint annuitant (reduced benefits taken to insure benefits for surviving spouse)
13 = Child of RR annuitant or Widow of annuitant with a child in her care
14 = Spouse of RR employee or annuitant (husband or wife)
15 = Parent of annuitant
16 = Widow/widower of RR annuitant
17 = Disabled adult child of RR annuitant
43 = Child of RR employee or Widow of employee with a child in her care
45 = Parent of employee
46 = Widow/widower of RR employee
83 = Widow of pensioner with a child in her care
86 = Widow/widower of RR pensioner

COMMENT: RRB definitions —

Employee: a Medicare beneficiary who is still working or a worker who died before retirement

Annuitant: a person who retired under the railroad retirement act on or after 03/01/37

Pensioner: a person who retired prior to 03/01/37 and was included in the railroad retirement act

^ Back to TOC ^

BENE_IP_DDCTBL_AMT

LABEL: Beneficiary’s liability for deductible for stay ($)

DESCRIPTION: The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the inpatient deductible for the stay.

SHORT NAME: DED_AMT

LONG NAME: BENE_IP_DDCTBL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the beneficiary inpatient deductible amount that is present on any of the claim records included in the stay (i.e., the sum of the inpatient deductibles reported on claims that comprise the stay).

^ Back to TOC ^

BENE_LRD_USE_CNT

LABEL: Lifetime reserve days (LRD) used by beneficiary for stay

DESCRIPTION: The count of the number of lifetime reserve days (LRD), if any, used by the beneficiary for this stay.

SHORT NAME: LRD_USE

LONG NAME: BENE_LRD_USE_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the LRD used count that is present on any of the claim records included in the stay (i.e., the sum of LRD reported on the claims that comprise the stay).

^ Back to TOC ^

BENE_MDCR_BNFT_EXHST_DT

LABEL: Beneficiary Medicare Benefit Exhausted Date

DESCRIPTION: The last date for which the beneficiary had Medicare coverage. This field is completed only where benefits were exhausted before the discharge date and during the period covered by stay.

SHORT NAME: EXHST_DT

LONG NAME: BENE_MDCR_BNFT_EXHST_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the highest benefits exhausted date that is present on the claim records included in the stay.

It is null/missing if benefits were not exhausted during the stay.

^ Back to TOC ^

BENE_MDCR_STUS_CD

LABEL: Reason for entitlement to Medicare benefits as of CLM_THRU_DT

DESCRIPTION: This variable indicates how a beneficiary qualifies for Medicare, as of the claim through date.

SHORT NAME: MS_CD

LONG NAME: BENE_MDCR_STUS_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

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

COMMENT: Analysts can use this variable to quickly distinguish between the aged, disabled, and ESRD populations.

This field is coded from age, original reason for entitlement, current reason for entitlement and ESRD indicator contained in the enrollment data base at CMS, as of the claim through date.

^ Back to TOC ^

BENE_MLG_CNTCT_ZIP_CD

LABEL: Zip code of the beneficiary's residence

DESCRIPTION: This field specifies the zip code identified as the beneficiary mailing address.

SHORT NAME: BENE_ZIP

LONG NAME: BENE_MLG_CNTCT_ZIP_CD

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the zip code that is present on the first claim record included in the stay.

In some cases, the code may not be the actual location where the beneficiary resides. CMS obtains the mailing address used for cash benefits or the mailing address used for other purposes (for example, premium billing) from Social Security Administration (SSA) and Railroad Retirement Board (RRB) Beneficiary Record Systems.

^ Back to TOC ^

BENE_PRMRY_PYR_AMT

LABEL: Primary Payer Paid Amount

DESCRIPTION: The amount of payment (rounded to whole dollars) made on behalf of the beneficiary by a primary payer other than Medicare, which has been applied to the covered Medicare charges for the stay.

SHORT NAME: PRPAYAMT

LONG NAME: BENE_PRMRY_PYR_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the primary payer payment amount that is present on any of the claim records included in the stay (i.e., the sum of the primary payer amounts reported on the claims that comprise the stay).

^ Back to TOC ^

BENE_PRMRY_PYR_CD

LABEL: Primary Payer Responsibility Code

DESCRIPTION: The code indicating the type of payer who has primary responsibility for the payment of the Medicare beneficiary's claims related to the stay (if not Medicare).

SHORT NAME: PRPAY_CD

LONG NAME: BENE_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: The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.

This field comes from the primary payer code that is present on the first claim record included in the stay.

^ Back to TOC ^

BENE_PTA_COINSRNC_AMT

LABEL: Beneficiary’s liability for part A coinsurance for stay ($)

DESCRIPTION: The amount of money (rounded to whole dollars) identified as the beneficiary's liability for Part A coinsurance for the stay.

SHORT NAME: COIN_AMT

LONG NAME: BENE_PTA_COINSRNC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the beneficiary's part a coinsurance liability amount that is present on any of the claim records included in the stay (i.e., the sum of coinsurance amounts reported on the claims that comprise the stay).

^ Back to TOC ^

BENE_RACE_CD

LABEL: Race of Beneficiary

DESCRIPTION: The race of the beneficiary.

SHORT NAME: RACE

LONG NAME: BENE_RACE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

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

COMMENT: This field comes from the race code that is present on the first claim record included in the stay.

^ Back to TOC ^

BENE_RSDNC_SSA_CNTY_CD

LABEL: SSA standard county code of the beneficiary's residence

DESCRIPTION: This code specifies the Social Security Administration (SSA) code for the county of identified through the beneficiary mailing address of the beneficiary.

SHORT NAME: CNTY_CD

LONG NAME: BENE_RSDNC_SSA_CNTY_CD

TYPE: CHAR

LENGTH: 3

SOURCE: NCH

VALUES: —

COMMENT: Each state has a series of codes beginning with '000' for each county within that state. Certain cities within that state have their own code.

County codes must be combined with state codes to locate the specific county. The coding system is the SSA system, not the Federal Information Processing Standard (FIPS).

In some cases, the code may not be the actual county where the beneficiary resides. CMS obtains the mailing address used for cash benefits or the mailing address used for other purposes (for example, premium billing) from Social Security Administration (SSA) and Railroad Retirement Board (RRB) Beneficiary Record Systems.

^ Back to TOC ^

BENE_RSDNC_SSA_STATE_CD

LABEL: SSA standard state code of the beneficiary's residence

DESCRIPTION: This variable is the two-digit Social Security Administration (SSA) code for the state identified as the beneficiary mailing address.

SHORT NAME: STATE_CD

LONG NAME: BENE_RSDNC_SSA_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 = US Possessions
97 = Saipan

98 = Guam
99 = American Samoa

XX = Unknown

COMMENT: This field comes from the state code that is present on the first claim record for the stay.

^ Back to TOC ^

BENE_SEX_CD

LABEL: Sex of Beneficiary

DESCRIPTION: The sex of the beneficiary

SHORT NAME: SEX

LONG NAME: BENE_SEX_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
0 = Unknown
2 = Female
1 = Male

COMMENT: This field comes from the sex code that is present on the first claim record included in the stay.

^ Back to TOC ^

BLOOD_ADMIN_CHRG_AMT

LABEL: Blood storage and processing charge amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for blood storage and processing related to the beneficiary's stay.

SHORT NAME: BLDADMIN

LONG NAME: BLOOD_ADMIN_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 039x from all claim records included in the stay.

^ Back to TOC ^

BLOOD_CHRG_AMT

LABEL: Blood Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for blood provided during the beneficiary's stay.

SHORT NAME: BLOODAMT

LONG NAME: BLOOD_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 038x from all claim records included in the stay.

^ Back to TOC ^

BLOOD_PT_FRNSH_QTY

LABEL: Blood Pints Furnished Quantity

DESCRIPTION: The number of whole pints of blood furnished to the beneficiary during the stay.

SHORT NAME: BLDFRNSH

LONG NAME: BLOOD_PT_FRNSH_QTY

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the blood pints furnished quantity from all claim records included in the stay.

This includes blood pints replaced as well as not replaced.

^ Back to TOC ^

BNDLD_ADJSTMT_AMT

LABEL: Bundled Payment Adjustment Amount

DESCRIPTION: This field represents the amount (rounded to whole dollars) the claim was reduced by. This field only applies to providers participating in the CMMI model 1 bundled payment program and the adjustment is calculated off the base operating DRG amount field.

SHORT NAME: BNDLD_ADJSTMT_AMT

LONG NAME: BNDLD_ADJSTMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the Claim inpatient prospective payment system (IPPS) bundled payment adjustment amount (previously referred to as the Flex Payment 2 Amount field; CLM_ IPPS_FLEX_PMT_2_AMT) that is present on any of the claim records included in the stay.

Reference the CMS Center for Medicare & Medicaid Innovation (CMMI: The Innovation Center) webpage for details on the Model 1 bundled payment program. http://innovation.cms.gov/initiatives/bundled-payments/.

This field is new in 2013.

^ Back to TOC ^

BNDLD_MODEL_DSCNT_PCT

LABEL: Bundled Payment Model Discount Percent

DESCRIPTION: The field used to identify the discount percentage that will be applied to the payment for all the hospitals' DRG over the lifetime of the Bundled Payments for Care Improvement initiative (BPCI, Model 1).

SHORT NAME: BNDLD_MODEL_DSCNT_PCT

LONG NAME: BNDLD_MODEL_DSCNT_PCT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: X.XXXX

COMMENT: The hospital must be participating in the Model 1 Bundled Payments for Care Improvement initiative (BPCI) — refer to CARE_IMPRVMT_MODEL_1_CD. The dollar amount of the payment reduction for the service is in the field called BNDLD_ADJSTMT_AMT.

This field comes from the Claim Bundled Model Discount (CLM-BNDLD-MODEL-1-DSCNT-PCT) that is present on the last record included in the stay.

Reference the CMS Center for Medicare & Medicaid Innovation (CMMI: The Innovation Center) webpage for details on the Model 1 bundled payment program. http://innovation.cms.gov/initiatives/bundled-payments/.

This field is new in 2012.

^ Back to TOC ^

CARE_IMPRVMT_MODEL_1_CD

CARE_IMPRVMT_MODEL_2_CD

CARE_IMPRVMT_MODEL_3_CD

CARE_IMPRVMT_MODEL_4_CD

LABEL: Care Improvement Model 1–4 Code

DESCRIPTION: The code used to identify that the care improvement model is being used for bundling payments.

SHORT NAME:

CARE_IMPRVMT_MODEL_1_CD
CARE_IMPRVMT_MODEL_2_CD
CARE_IMPRVMT_MODEL_3_CD
CARE_IMPRVMT_MODEL_4_CD

LONG NAME:

CARE_IMPRVMT_MODEL_1_CD
CARE_IMPRVMT_MODEL_2_CD
CARE_IMPRVMT_MODEL_3_CD
CARE_IMPRVMT_MODEL_4_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: 61 = CLAIM CARE IMPROVEMENT MODEL 1–4

Null/missing = Not Model 1

COMMENT: This field comes from the Claim Care Improvement Model (CLM_CARE_IMPRVMT_MODEL_1_CD–CLM_CARE_IMPRVMT_MODEL_4_CD) code that is present on the first claim record included in the stay. If there is no Claim Care Improve Model code on the 1st claim, then take the first found code on the other claims that make up the stay.

This field is new in 2013.

This value is also reflected in the demonstration trailer of the claim.

^ Back to TOC ^

CELL_GENE_THRPY_PRCDRS_TOT_AMT

LABEL: Cell/Gene Therapy Procedures Total Charge Amount

DESCRIPTION: This field contains the total charge amount for cell/gene therapy procedures.

SHORT NAME: CELL_GENE_THRPY_PRCDRS_TOT_AMT

LONG NAME: CELL_GENE_THRPY_PRCDRS_TOT_AMT

TYPE: NUM

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 087x from all claim records included in the stay.

This field is new in 2019.

^ Back to TOC ^

CELL_THRPY_DRUGS_TOT_AMT

LABEL: Cell Therapy Drugs Total Charge Amount

DESCRIPTION: This field contains the total charge amount for cell therapy drugs.

SHORT NAME: CELL_THRPY_DRUGS_TOT_AMT

LONG NAME: CELL_THRPY_DRUGS_TOT_AMT

TYPE: NUM

LENGTH: 10

SOURCE: NCH

VALUES: XXXXXX

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0891 from all claim records included in the stay.

This field is new in 2019.

^ Back to TOC ^

CLM_FULL_STD_PYMT_AMT

LABEL: Claim Full Standard Payment Amount

DESCRIPTION: Under the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS), the payment amount 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: 8

SOURCE: NCH

VALUES: XXXXXX

COMMENT: This field is derived by accumulating the amount field (CLM_FULL_STD_PMT_AMT) that is present on any of the claim records included in the stay (i.e., sum of the CLM_FULL_STD_PMT_AMT reported on the claims that comprised the LTCH stay).

This field is new in 2015.

^ Back to TOC ^

CLM_IP_INITL_MS_DRG_CD

LABEL: Claim Inpatient Initial MS-DRG Code

DESCRIPTION: This field comes from the Claim Inpatient Initial MS DRG Code field (CLM-IP-INITL-MS-DRG-CD) that is present on the first NCH claim record included in the stay. If there is no CLM-IP-INITL-MS-DRG-CD on the 1st claim, then take the first found code on any of the other claims that make up the stay.

SHORT NAME: CLM_IP_INITL_MS_DRG_CD

LONG NAME: CLM_IP_INITL_MS_DRG_CD

TYPE: CHAR

LENGTH: 4

SOURCE: NCH

VALUES: XXXXXX

COMMENT: This field is new in 2018.

^ Back to TOC ^

CLM_MODEL_REIMBRSMT_AMT

LABEL: Claim Model Reimbursement Amount

DESCRIPTION: This field contains 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 (zero). If the claim includes global services and non-global services, the reimbursement amount will reflect the amount Medicare actually paid for the non-global services.

SHORT NAME: CLM_MODEL_REIMBRSMT_AMT

LONG NAME: CLM_MODEL_REIMBRSMT_AMT

TYPE: NUM

LENGTH: 10

SOURCE: NCH

VALUES: XXXXXX

COMMENT: This field is derived by accumulating the Claim Model Reimbursement Amount (CLM-MODEL-REIMBRSMT-AMT) that is present on any of the claim records included in the stay (i.e., sum of the CLM-MODEL-REIMBRSMT-AMT reported on the claims that comprised the stay).

NOTE: This field will be used with future models and not just the Pennsylvania Rural Health Model (PARHM) (CR11355). A demo code (CLM_DEMO_ID_NUM) will be assigned for future models. CLM_RLT_COND_CD = M6 and CLM_VAL_CD = Q4 have been created to identify the PARH model.

This field is new in 2019.

^ Back to TOC ^

CLM_NGACO_IND_1_CD

CLM_NGACO_IND_2_CD

CLM_NGACO_IND_3_CD

CLM_NGACO_IND_4_CD

CLM_NGACO_IND_5_CD

LABEL: Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code 1–5

DESCRIPTION: This field represents the benefit enhancement indicator that identifies these are Next Generation (NG) Accountable Care Organization (ACO) claims that qualify for specific claims processing edits.

SHORT NAME:

CLM_NGACO_IND_1_CD
CLM_NGACO_IND_2_CD
CLM_NGACO_IND_3_CD
CLM_NGACO_IND_4_CD
CLM_NGACO_IND_5_CD

LONG NAME:

CLM_NGACO_IND_1_CD
CLM_NGACO_IND_2_CD
CLM_NGACO_IND_3_CD
CLM_NGACO_IND_4_CD
CLM_NGACO_IND_5_CD

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

COMMENT: This field comes from the CLM-NG-ACO-IND-1-CD–CLM-NG-ACO-IND-5-CD that is present on the first claim record included in the stay. If there is no CLM-NG-ACO-IND-1-CD–CLM-NG-ACO-IND-5-CD on the first claim, then take the first found code on any of the other claims that make up the stay.

This field is new in 2015.

^ Back to TOC ^

CLM_PTNT_RLTNSHP_CD

LABEL: Claim Patient Relationship Code

DESCRIPTION: The code used to identify the patient relationship to the beneficiary.

SHORT NAME: CLM_PTNT_RLTNSHP_CD

LONG NAME: CLM_PTNT_RLTNSHP_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES: 18 = Patient is insured
39 = Organ donor Null/missing

COMMENT: This field is new in 2011. It comes from the patient relationship code (CLM-PTNT-RLTNSHP-CD) that is present on the first claim record included in the stay. If there is no patient relationship code on the 1st claim, then take the first found code on any of the other claims that make up the stay.

^ Back to TOC ^

CLM_RP_IND_CD

LABEL: Claim Representative Payee (RP) Indicator Code

DESCRIPTION: This is a claim level field to designate bypassing of the prior authorization processing for claims with a representative payee when an 'R' is present in the field.

SHORT NAME: CLM_RP_IND_CD

LONG NAME: CLM_RP_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: R = bypass representative payee

COMMENT: This field comes from the CLM-RP-IND-CD that is present on the first claim record included in the stay. If there is no CLM-RP-IND-CD on the first claim, then take the first found code (R) on any of the other claims that make up the stay.

This field is new in 2015.

Note that there is also a Revenue Center Representative Payee (RP) Indicator Code (SAS variable called RC_RP_IND_CD).

^ Back to TOC ^

CLM_RSDL_PYMT_IND_CD

LABEL: Claim Residual Payment Indicator Code

DESCRIPTION: This is a claim level field to the indicator used by CWF claims processing for the purpose of bypassing its normal MSP editing that would otherwise apply to ongoing responsibility for medicals (ORM) or worker's compensation Medicare Set-Aside Arrangements (WCMSA).

SHORT NAME: CLM_RSDL_PYMT_IND_CD

LONG NAME: CLM_RSDL_PYMT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: X = Residual Payment

COMMENT: Normally, CWF does not allow a secondary payment on MSP involving ORM or WCMSA, so the RPI will be used to allow CWF to make an exception to its normal routine.

This field comes from the Claim Residual Payment Indicator Code (CLM-RSDL-PMT-IND-CD) that is present on the first claim record included in the stay. If there is no CLM-RSDL-PMT-IND-CD on the 1st claim, then take the first-round code on any of the other claims that make up the stay.

This field is new in 2015.

^ Back to TOC ^

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: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the amount field (CLM-SITE-NTRL-PMT-CST-AMT) that is present on any of the claim records included in the stay (i.e., sum of the CLM-SITE-NTRL-PMT-CST-AMT reported on the claims that comprised the LTCH stay).

This field is new in 2015.

^ Back to TOC ^

CLM_SITE_NTRL_PYMT_IPPS_AMT

LABEL: Claim Site Neutral Payment Based on IPPS Amount

DESCRIPTION: Under the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS), the payment amount based on the Inpatient Prospective Payment (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: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the amount field (CLM-SITE-NTRL-PMT-IPPS-AMT) that is present on any of the claim records included in the stay (i.e., sum of the CLM-SITE-NTRL-PMT-IPPS-AMT reported on the claims that comprised the LTCH stay).

This field is new in 2015.

^ Back to TOC ^

CLM_SS_OUTLIER_STD_PYMT_AMT

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

DESCRIPTION: Under the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS), the payment amount based on the MS-LTC-DRG payment with short stay outlier (SSO) adjustment.

SHORT NAME: CLM_SS_OUTLIER_STD_PYMT_AMT

LONG NAME: CLM_SS_OUTLIER_STD_PYMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: XXXXXX

COMMENT: This amount does not include any applicable outlier payment amount.

This field is derived by accumulating the amount field (CLM_SSO_STD_PMT_AMT) that is on any of the claim records included in the stay (i.e., sum of the CLM_SSO_STD_PMT_AMT reported on the claims that comprised the stay).

This field is new in 2015.

^ Back to TOC ^

CLNCL_TRIL_SW

LABEL: Other Clinical Trial Switch

DESCRIPTION: This variable indicates that the service was provided as part of a clinical trial of a different product.

SHORT NAME: CLNCL_TRIL_SW

LONG NAME: CLNCL_TRIL_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH (derived)

VALUES: Y = Yes
N = No

COMMENT: This field was new in 2021.

This field is derived when the condition code (CLM RLT COND CD) is equal to “ZC”, populate the field with a “Y”. If no “ZC” condition code, populate field with an “N”.

^ Back to TOC ^

CLNC_VISIT_CHRG_AMT

LABEL: Clinic Visit Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for clinic visits (e.g., visits to chronic pain or dental centers or to clinics providing psychiatric, OB-GYN, pediatric services) related to the beneficiary's stay.

SHORT NAME: CLNC_AMT

LONG NAME: CLNC_VISIT_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 051x from all claim records included in the stay.

^ Back to TOC ^

CRDC_CATHRZTN_AMT

LABEL: Cardiac Catheterization Lab Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the cardiac catheterization lab related to the beneficiary's stay.

SHORT NAME: CRDC_CATHRZTN_AMT

LONG NAME: CRDC_CATHRZTN_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0481' from all claim records included in the stay. This field was new in 2011.

^ Back to TOC ^

CRDLGY_CHRG_AMT

LABEL: Cardiology Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for cardiology services and electrocardiogram(s) provided during the beneficiary's stay.

SHORT NAME: CRDLGY

LONG NAME: CRDLGY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 048X and 073X from all claim records included in the stay.

^ Back to TOC ^

CRED_RCVD_RPLCD_DVC_SW

LABEL: Credit Received Replaced Device

DESCRIPTION: The switch used to identify whether the provider received a credit from the Manufacturer for a replaced medical device.

SHORT NAME: CRED_RCVD_RPLCD_DVC_SW

LONG NAME: CRED_RCVD_RPLCD_DVC_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = credit received
N = no credit received

COMMENT: If any claim that comprises the Stay has a value code (CLM-VAL-CD) equal to 'FD' populate the MEDPAR Credit Received from Manufacturer for Replaced Medical Device Switch with a 'Y'. If no 'FD' value code, populate field with an 'N'.

^ Back to TOC ^

CRNRY_CARE_CHRG_AMT

LABEL: Coronary Care Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for coronary care accommodations related to a beneficiary's stay.

SHORT NAME: CRNRYAMT

LONG NAME: CRNRY_CARE_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with accommodation revenue center code 021X from all claim records included in the stay.

^ Back to TOC ^

CRNRY_CARE_DAY_CNT

LABEL: Coronary Care Day Count

DESCRIPTION: The count of the number of coronary care unit (CCU) days used by the beneficiary for the stay.

SHORT NAME: CRNRYDAY

LONG NAME: CRNRY_CARE_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center unit count associated with accommodation revenue center code 021X from all claim records included in the stay.

There is approximately a 20% error rate in the revenue center code category 0214 due to coders misunderstanding the term 'post CCU' as including any day after a CCU stay rather than just days in a step-down/lower case version of a CCU. 'Post' was removed from the revenue center code 0214 description, effective 10/1/96 (12/96 MEDPAR update). 0214 Is now defined as 'intermediate CCU'.

^ Back to TOC ^

CRNRY_CARE_IND_CD

LABEL: Coronary Care Unit (CCU) Indicator Code

DESCRIPTION: The code indicating that the beneficiary has spent time under coronary care during the stay. It also specifies the type of coronary care unit.

SHORT NAME: CRNRY_CD

LONG NAME: CRNRY_CARE_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: Missing/null = No coronary care indication
0 = General (revenue code 0210)
1 = Myocardial (revenue code 0211)
2 = Pulmonary care (revenue code 0212)
3 = Heart transplant (revenue code 0213)
4 = Intermediate CCU (revenue code 0214)
9 = Other Coronary Care (revenue code 0219)

COMMENT: This field is derived by checking for the presence of coronary care revenue center codes (021X) on any of the claim records included in the stay. If more than one of the revenue center codes are included on these claims; the code with the highest revenue center total charge amount is used.

There is approximately a 20% error rate in the revenue center code category 0214 due to coders misunderstanding the term 'post CCU' as including any day after a CCU stay rather than just days in a step-down/lower case version of a CCU. 'Post' was removed from the revenue center code 0214 description, effective 10/1/96 (12/96 MEDPAR update). 0214 is now defined as 'intermediate CCU'.

^ Back to TOC ^

CVRD_LVL_CARE_THRU_DT

LABEL: Date covered level of care ended in a SNF

DESCRIPTION: The date on which a covered level of care ended in a SNF.

SHORT NAME: CVRLVLDT

LONG NAME: CVRD_LVL_CARE_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the date associated with occurrence code = 22 if present on any of the claims included in the stay. If multiple dates, the highest date is used.

This field is only applicable to SNF claims.

^ Back to TOC ^

DGNS_1_CD

DGNS_2_CD

DGNS_3_CD

DGNS_4_CD

DGNS_5_CD

DGNS_6_CD

DGNS_7_CD

DGNS_8_CD

DGNS_9_CD

DGNS_10_CD

DGNS_11_CD

DGNS_12_CD

DGNS_13_CD

DGNS_14_CD

DGNS_15_CD

DGNS_16_CD

DGNS_17_CD

DGNS_18_CD

DGNS_19_CD

DGNS_20_CD

DGNS_21_CD

DGNS_22_CD

DGNS_23_CD

DGNS_24_CD

DGNS_25_CD

LABEL: Principal Diagnosis Code

DESCRIPTION: The diagnosis code identifying the beneficiary's principal diagnosis.

SHORT NAME:

DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD1
DGNSCD11
DGNSCD12
DGNSCD13
DGNSCD14
DGNSCD15
DGNSCD16
DGNSCD17
DGNSCD18
DGNSCD19
DGNSCD20
DGNSCD21
DGNSCD22
DGNSCD23
DGNSCD24
DGNSCD25

LONG NAME:

DGNS_1_CD
DGNS_2_CD
DGNS_3_CD
DGNS_4_CD
DGNS_5_CD
DGNS_6_CD
DGNS_7_CD
DGNS_8_CD
DGNS_9_CD
DGNS_10_CD
DGNS_11_CD
DGNS_12_CD
DGNS_13_CD
DGNS_14_CD
DGNS_15_CD
DGNS_16_CD
DGNS_17_CD
DGNS_18_CD
DGNS_19_CD
DGNS_20_CD
DGNS_21_CD
DGNS_22_CD
DGNS_23_CD
DGNS_24_CD
DGNS_25_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: The principal diagnosis code is stored as the first diagnosis code (DGNSCD1).

Until 2009, there were up to 9 diagnosis codes; currently there are up to 25 (i.e., diagnosis codes 1–25).

ICD-10 diagnosis codes were used starting October 2015. The diagnosis version code (variables DGNS_VRSN_CD_1–DGNS_VRSN_CD_25) indicates whether this diagnosis code is ICD-9 or ICD-10.

^ Back to TOC ^

DGNS_CD_CNT

LABEL: Count of Diagnosis Codes

DESCRIPTION: The count of the number of diagnosis codes included in the stay.

SHORT NAME: DGNSCNT

LONG NAME: DGNS_CD_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by adding '1' to the count of the other diagnosis codes reported on the last claim record included in the stay. The '1' represents the principal diagnosis code, which is reported separately from the other diagnosis.

^ Back to TOC ^

DGNS_E_1_CD

DGNS_E_2_CD

DGNS_E_3_CD

DGNS_E_4_CD

DGNS_E_5_CD

DGNS_E_6_CD

DGNS_E_7_CD

DGNS_E_8_CD

DGNS_E_9_CD

DGNS_E_10_CD

DGNS_E_11_CD

DGNS_E_12_CD

LABEL: Diagnosis E Code 1

DESCRIPTION: The diagnosis code is used to identify the 1st E code reported on the Inpatient/SNF claim. There are up to 12 E codes, which are used to identify external causes of injury, poisoning, or other adverse events.

SHORT NAME:

DGNS_E_1_CD
DGNS_E_2_CD
DGNS_E_3_CD
DGNS_E_4_CD
DGNS_E_5_CD
DGNS_E_6_CD
DGNS_E_7_CD
DGNS_E_8_CD
DGNS_E_9_CD
DGNS_E_10_CD
DGNS_E_11_CD
DGNS_E_12_CD

LONG NAME:

DGNS_E_1_CD
DGNS_E_2_CD
DGNS_E_3_CD
DGNS_E_4_CD
DGNS_E_5_CD
DGNS_E_6_CD
DGNS_E_7_CD
DGNS_E_8_CD
DGNS_E_9_CD
DGNS_E_10_CD
DGNS_E_11_CD
DGNS_E_12_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: This field was new in 2009.

ICD-10 diagnosis codes were used starting October 2015. The diagnosis version code for these 12 E code diagnoses appears in variables DGNS_E_VRSN_CD_1–DGNS_E_VRSN_CD_12, which indicates whether this diagnosis code is ICD-9 or ICD-10.

^ Back to TOC ^

DGNS_E_CD_CNT

LABEL: Count of Diagnosis E Codes

DESCRIPTION: The count of the number of diagnosis E codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many diagnosis E trailers are present.

SHORT NAME: DGNS_E_CD_CNT

LONG NAME: DGNS_E_CD_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: 0 to 12

COMMENT: This field was new in 2009.

^ Back to TOC ^

DGNS_E_VRSN_CD

LABEL: Diagnosis E Version Code (Earlier Version)

DESCRIPTION: The code is used to indicate if the diagnosis E code is ICD-9 or ICD-10.

SHORT NAME: DGNS_E_VRSN_CD

LONG NAME: DGNS_E_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null/missing = ICD-9
9 = ICD-9
0 = ICD-10

COMMENT: ICD-10 codes were used starting October 2015.

This field was populated only in 2009 and 2010.

^ Back to TOC ^

DGNS_E_VRSN_CD_1

DGNS_E_VRSN_CD_2

DGNS_E_VRSN_CD_3

DGNS_E_VRSN_CD_4

DGNS_E_VRSN_CD_5

DGNS_E_VRSN_CD_6

DGNS_E_VRSN_CD_7

DGNS_E_VRSN_CD_8

DGNS_E_VRSN_CD_9

DGNS_E_VRSN_CD_10

DGNS_E_VRSN_CD_11

DGNS_E_VRSN_CD_12

LABEL: Diagnosis E Version Code 1

DESCRIPTION: The code used to indicate if the 1st diagnosis E code is ICD-9 or ICD-10.

SHORT NAME:

DGNS_E_VRSN_CD_1
DGNS_E_VRSN_CD_2
DGNS_E_VRSN_CD_3
DGNS_E_VRSN_CD_4
DGNS_E_VRSN_CD_5
DGNS_E_VRSN_CD_6
DGNS_E_VRSN_CD_7
DGNS_E_VRSN_CD_8
DGNS_E_VRSN_CD_9
DGNS_E_VRSN_CD_10
DGNS_E_VRSN_CD_11
DGNS_E_VRSN_CD_12

LONG NAME:

DGNS_E_VRSN_CD_1
DGNS_E_VRSN_CD_2
DGNS_E_VRSN_CD_3
DGNS_E_VRSN_CD_4
DGNS_E_VRSN_CD_5
DGNS_E_VRSN_CD_6
DGNS_E_VRSN_CD_7
DGNS_E_VRSN_CD_8
DGNS_E_VRSN_CD_9
DGNS_E_VRSN_CD_10
DGNS_E_VRSN_CD_11
DGNS_E_VRSN_CD_12

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null/missing = ICD-9
9 = ICD-9

0 = ICD-10

COMMENT: There are up to 12 diagnosis E codes (variables called DGNS_E_1_CD–DGNS_E_12_CD), which are used to identify external causes of injury, poisoning, or other adverse events.

ICD-10 diagnosis codes were used starting October 2015. The diagnosis version code for these 12 E code diagnoses appears in variables DGNS_E_VRSN_CD_1–DGNS_E_VRSN_CD_12, which indicates whether this diagnosis code is ICD-9 or ICD-10.

This field was new in 2009.

^ Back to TOC ^

DGNS_POA_CD

LABEL: Diagnosis Code POA Array

DESCRIPTION: MEDPAR Diagnosis Code Present on Admission (POA) Array

SHORT NAME: DGNS_POA

LONG NAME: DGNS_POA_CD

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is only populated in 2007-08. Starting in 2009 this field is replaced with POA_DGNS_#_IND_CD (where # = 1-25).

^ Back to TOC ^

DGNS_VRSN_CD

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

DESCRIPTION: The code is used to indicate if the diagnosis code is ICD-9 or ICD-10.

SHORT NAME: DGNS_VRSN_CD

LONG NAME: DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null/missing = ICD-9
9 = ICD-9
0 = ICD-10

COMMENT: ICD-10 codes were used starting October 2015.

This field was populated only in 2009 and 2010. Starting in 2011 this field is replaced with DGNS_VRSN_CD_## (where # = 1-25).

^ Back to TOC ^

DGNS_VRSN_CD_1

DGNS_VRSN_CD_2

DGNS_VRSN_CD_3

DGNS_VRSN_CD_4

DGNS_VRSN_CD_5

DGNS_VRSN_CD_6

DGNS_VRSN_CD_7

DGNS_VRSN_CD_8

DGNS_VRSN_CD_9

DGNS_VRSN_CD_10

DGNS_VRSN_CD_11

DGNS_VRSN_CD_12

DGNS_VRSN_CD_13

DGNS_VRSN_CD_14

DGNS_VRSN_CD_15

DGNS_VRSN_CD_16

DGNS_VRSN_CD_17

DGNS_VRSN_CD_18

DGNS_VRSN_CD_19

DGNS_VRSN_CD_20

DGNS_VRSN_CD_21

DGNS_VRSN_CD_22

DGNS_VRSN_CD_23

DGNS_VRSN_CD_24

DGNS_VRSN_CD_25

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

DESCRIPTION: The code used to indicate if the 1st diagnosis code (the principal diagnosis) is ICD-9 or ICD-10.

SHORT NAME:

DGNS_VRSN_CD_1
DGNS_VRSN_CD_2
DGNS_VRSN_CD_3
DGNS_VRSN_CD_4
DGNS_VRSN_CD_5
DGNS_VRSN_CD_6
DGNS_VRSN_CD_7
DGNS_VRSN_CD_8
DGNS_VRSN_CD_9
DGNS_VRSN_CD_10
DGNS_VRSN_CD_11
DGNS_VRSN_CD_12
DGNS_VRSN_CD_13
DGNS_VRSN_CD_14
DGNS_VRSN_CD_15
DGNS_VRSN_CD_16
DGNS_VRSN_CD_17
DGNS_VRSN_CD_18
DGNS_VRSN_CD_19
DGNS_VRSN_CD_20
DGNS_VRSN_CD_21
DGNS_VRSN_CD_22
DGNS_VRSN_CD_23
DGNS_VRSN_CD_24
DGNS_VRSN_CD_25

LONG NAME:

DGNS_VRSN_CD_1
DGNS_VRSN_CD_2
DGNS_VRSN_CD_3
DGNS_VRSN_CD_4
DGNS_VRSN_CD_5
DGNS_VRSN_CD_6
DGNS_VRSN_CD_7
DGNS_VRSN_CD_8
DGNS_VRSN_CD_9
DGNS_VRSN_CD_10
DGNS_VRSN_CD_11
DGNS_VRSN_CD_12
DGNS_VRSN_CD_13
DGNS_VRSN_CD_14
DGNS_VRSN_CD_15
DGNS_VRSN_CD_16
DGNS_VRSN_CD_17
DGNS_VRSN_CD_18
DGNS_VRSN_CD_19
DGNS_VRSN_CD_20
DGNS_VRSN_CD_21
DGNS_VRSN_CD_22
DGNS_VRSN_CD_23
DGNS_VRSN_CD_24
DGNS_VRSN_CD_25

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null/missing = ICD-9
9 = ICD-9
0 = ICD-10

COMMENT: There are up to 25 diagnosis codes (variables called DGNSCD1–DGNSCD25).

ICD-10 codes were used starting October 2015.The diagnosis version code for these 25 diagnoses appears in variables DGNS_VRSN_CD_1–DGNS_VRSN_CD_25, which indicates whether this diagnosis code is ICD-9 or ICD-10.

This field was new in 2011.

^ Back to TOC ^

DME_CHRG_AMT

LABEL: Durable Medical Equipment (DME) Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for durable medical equipment (DME) (purchase of new DME and rentals) related to the beneficiary's stay.

SHORT NAME: DME_AMT

LONG NAME: DME_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0290, 0291, 0292, and 0294–0299 from all claim records included in the stay.

Note that an additional field contains charge amounts for used DME (variable called UDME_AMT).

^ Back to TOC ^

DPRTMNTL_TOT_CHRG_AMT

LABEL: Total charge for all ancillary departments related to beneficiary's stay ($)

DESCRIPTION: The total charge amount (rounded to whole dollars) for all ancillary departments (other than routine room and board, CCU, and ICU) related to a beneficiary's stay.

SHORT NAME: DPRTMNTL

LONG NAME: DPRTMNTL_TOT_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0220–0999 from all claim records included in the stay (i.e., the sum of charges for all revenue centers other than accommodations 0100–0219).

^ Back to TOC ^

DRG_CD

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

DESCRIPTION: The code indicating the Diagnosis Related Group (or MS-DRG) to which the claims that comprise the stay belong for payment purposes.

SHORT NAME: DRG_CD

LONG NAME: DRG_CD

TYPE: CHAR

LENGTH: 4

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the actual DRG code (or MS-DRG code) that is present on the last claim record included in the stay.

The exception is if the DRG code is not present (e.g., claims from Maryland and PPS-exempt hospital units do not have a DRG), then a valid DRG is obtained using the grouper software and is moved to this field.

^ Back to TOC ^

DRG_GRPR_VRSN _CD

LABEL: Medicare-Severity Diagnosis Related Group (MS-DRG) Grouper Version

DESCRIPTION: This variable displays the MS-DRG grouper version.

SHORT NAME: DRG_GRPR_VRSN_CD

LONG NAME: DRG_GRPR_VRSN_CD

TYPE: CHAR

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field was new in 2021.

^ Back to TOC ^

DRG_OUTLIER_PMT_AMT

LABEL: DRG Outlier Approved Payment Amount ($)

DESCRIPTION: The amount of additional payment (rounded to whole dollars) approved due to an outlier situation over the DRG allowance for the stay.

SHORT NAME: OUTLRAMT

LONG NAME: DRG_OUTLIER_PMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the DRG outlier approved payment amount (value code = 17 amount) that is present on any of the claim records included in the stay (i.e., the sum of outlier amounts reported on the claims that comprise the stay).

This amount is already included in the MEDPAR Medicare payment amount (field called PMT_AMT).

^ Back to TOC ^

DRG_OUTLIER_STAY_CD

LABEL: DRG Cost or Day Outlier code

DESCRIPTION: The code identifying if the stay has an unusually long length (day outlier) or high cost (cost outlier).

SHORT NAME: OUTLR_CD

LONG NAME: DRG_OUTLIER_STAY_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: For PPS providers:
0 = No Outlier
1 = Day Outlier
2 = Cost Outlier
For Non-PPS Providers:
6 = Valid DRG Received from Intermediary
7 = HCFA-Developed DRG
8 = HCFA-Developed DRG Using Claim Status Code
9 = Not Groupable

COMMENT: This field is the actual DRG outlier stay code that is present on the last claim record included in the stay for PPS providers.

For non-PPS providers, the DRG is obtained using the grouper software and outliers are identified.

^ Back to TOC ^

DRG_PRICE_AMT

LABEL: DRG Price Amount ($)

DESCRIPTION: The amount (called the 'DRG price' for purposes of MEDPAR analysis) that would have been paid if no deductibles, coinsurance, primary payers, or outliers were involved (rounded to whole dollars).

SHORT NAME: DRGPRICE

LONG NAME: DRG_PRICE_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the following amounts:

MEDPAR Medicare payment amount, MEDPAR beneficiary primary payer payment amount, MEDPAR beneficiary coinsurance liability amount, MEDPAR beneficiary Inpatient deductible liability amount, MEDPAR beneficiary blood deductible amount; and then subtracting from the sum the MEDPAR DRG outlier approved payment amount.

^ Back to TOC ^

DSCHRG_DSTNTN_CD

LABEL: Destination upon discharge from facility code

DESCRIPTION: The code indicating the destination of the beneficiary upon discharge from a facility; also denotes death or skilled nursing facility (SNF)/still patient situations.

SHORT NAME: DSTNTNCD

LONG NAME: DSCHRG_DSTNTN_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
01 = Discharged to home/self-care (routine charge).
02 = Discharged/transferred to other short term general hospital for inpatient care.
03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care — (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.
04 = Discharged/transferred to intermediate care facility (ICF).
05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).

NOTE: 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'.

06 = Discharged/transferred to home care of organized home health service organization.
07 = Left against medical advice or discontinued care.
08 = Discharged/transferred to home under care of a home IV drug therapy provider.
20 = Expired (patient did not recover).
21 = Discharged/transferred to court/law enforcement
30 = Still patient.
43 = Discharged/transferred to a federal hospital (eff. 10/1/03)
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. 9/01)
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 hospitals. (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. 1/1/06)

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. 9/01) (discontinued effective 10/1/05)
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
The following codes apply only to particular MS-DRGs*, and were new in 10/2013:
81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission.
82 = Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission.
83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission.
84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.
85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission.
86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.
87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.
88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission.
89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.
90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.
91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.
92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.
93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.
94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.
95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

COMMENT: * MS-DRG codes where additional codes were available 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).

This field comes from the claim status code that is present on the last claim record for the stay.

^ Back to TOC ^

DSCHRG_DT

LABEL: Date beneficiary was discharged or died

DESCRIPTION: The date on which the beneficiary was discharged or died.

SHORT NAME: DSCHRGDT

LONG NAME: DSCHRG_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the highest claim thru date that is present on the claim records included in the stay, where the claim status code is other than '30' (still patient) on the last claim record included in the stay.

Inpatient claims will always have a discharge date; SNF claims could have a zero date.

^ Back to TOC ^

EHR_PYMT_ADJSTMT_AMT

LABEL: Electronic Health Record (EHR) Payment Adjustment Amount

DESCRIPTION: The amount field (rounded to whole dollars) that represents the Electronic Health Record (EHR) Payment reduction for eligible hospitals that are not meaningful EHR users.

SHORT NAME: EHR_PYMT_ADJSTMT_AMT

LONG NAME: EHR_PYMT_ADJSTMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is new in October 2014. This field only applies to Inpatient claims.

^ Back to TOC ^

EMER _USE_SW

LABEL: Emergency Use Switch

DESCRIPTION: This variable indicates that the service was provided as part of an emergency use authorization (EUA).

SHORT NAME: EMER_USE_SW

LONG NAME: EMER_USE_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH (derived)

VALUES: Y = Yes
N = No

COMMENT: This field was new in 2021.

This field is derived when the condition code (CLM RLT COND CD) is equal to “91”, populate the field with a “Y”. If no “91” condition code, populate field with an “N”.

^ Back to TOC ^

EQTBL_BIC_CD

LABEL: Equated BIC

DESCRIPTION: The code which categorizes groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

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

NOTE: This field comes from the NCH category base BIC that is present on the first claim record included in the stay.

SHORT NAME: EQ_BIC

LONG NAME: EQTBL_BIC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
A = Primary claimant
B = Aged wife, age 62 or over (1st claimant)
B1 = Aged husband, age 62 or over (1st claimant)
B2 = Young wife, with a child in her care (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)

C1-C9, CA-CZ = Child (includes minor, student, or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of age 60) (1st claimant)
D5 = Widower (remarried after attainment of age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over (1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)
DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than3 Q.C.) (general fund) (1st claimant)
M = Uninsured-not qualified for deemed HIB
T = Uninsured entitled to HIB under deemed or renal provisions

TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
W = Disabled widow, age 50 or over (1st claimant)
W1 = Disabled widower, age 50 or over (1st claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st claimant)
W7 = Disabled surviving divorced wife (2nd claimant)
W8 = Disabled surviving divorced wife (3rd claimant)
W9 = Disabled widow (4th claimant)
WR = Disabled surviving divorced husband (1st claimant)
WT = Disabled surviving divorced husband (2nd claimant)
Railroad Retirement Board (RRB):
10 = Retirement - employee or annuitant
11 = Survivor joint annuitant (reduced benefits taken to insure benefits for surviving spouse)
13 = Child of RR annuitant or Widow of annuitant with a child in her care
14 = Spouse of RR employee or annuitant (husband or wife)
15 = Parent of annuitant
16 = Widow/widower of RR annuitant
17 = Disabled adult child of RR annuitant
43 = Child of RR employee or Widow of employee with a child in her care
45 = Parent of employee
46 = Widow/widower of RR employee
83 = Widow of pensioner with a child in her care
86 = Widow/widower of RR pensioner

COMMENT: RRB definitions –

Employee: a Medicare beneficiary who is still working or a worker who died before retirement
Annuitant: a person who retired under the railroad retirement act on or after 03/01/37
Pensioner: a person who retired prior to 03/01/37 and was included in the railroad retirement act

^ Back to TOC ^

ER_CHRG_AMT

LABEL: Emergency Room (ER) Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for emergency room (ER) services provided during the beneficiary's stay.

SHORT NAME: ER_AMT

LONG NAME: ER_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 045x from all claim records included in the stay.

^ Back to TOC ^

ESRD_COND_CD

LABEL: End Stage Renal Disease (ESRD) Condition Indicator Code

DESCRIPTION: The code indicating if the beneficiary had an end stage renal disease (ESRD) condition reported during the stay.

SHORT NAME: ESRD_CD

LONG NAME: ESRD_COND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: MedPAR (derived)

VALUES: 00 = No dialysis or ESRD services

71 = 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.

COMMENT: This field is derived by checking for condition codes 70–76 on any of the claim records included in the stay.

^ Back to TOC ^

ESRD_REV_SETG_CHRG_AMT

LABEL: End Stage Renal Disease (ESRD) charge amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for ESRD services (other than organ acquisition and other donor bank) related to a beneficiary's stay.

NOTE: Effective with MEDPAR2000 expansion, all amount fields were expanded from S9(7) to S9(9).

SHORT NAME: ESRDSETG

LONG NAME: ESRD_REV_SETG_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 080x, 082x–088x from all claim records included in the stay.

^ Back to TOC ^

ESRD_SETG_IND_1_CD

ESRD_SETG_IND_2_CD

ESRD_SETG_IND_3_CD

ESRD_SETG_IND_4_CD

ESRD_SETG_IND_5_CD

LABEL: Dialysis service type code 1

DESCRIPTION: The 1st code indicating the type of dialysis received by the beneficiary during the stay. Up to five (5) of these 2-position codes may be present.

SHORT NAME:

ESRDSTG1
ESRDSTG2
ESRDSTG3
ESRDSTG4
ESRDSTG5

LONG NAME:

ESRD_SETG_IND_1_CD
ESRD_SETG_IND_2_CD
ESRD_SETG_IND_3_CD
ESRD_SETG_IND_4_CD
ESRD_SETG_IND_5_CD

TYPE: CHAR

LENGTH: 2

SOURCE: MedPAR (derived)

VALUES:
00 = IP renal dialysis-general (revenue code 0800)
01 = IP renal dialysis-hemodialysis (revenue code 0801)
02 = IP renal dialysis-peritoneal (non-CAPD: revenue code 0802)
03 = IP renal dialysis-Continuous Ambulatory Peritoneal Dialysis (CAPD) (revenue code 0803)
04 = IP renal dialysis-Continuous Cycling Peritoneal Dialysis (CCPD) (revenue code 0804)
09 = IP renal dialysis-other (revenue code 0809)
20 = Hemodialysis-OP-general (revenue code 0820)
21 = Hemodialysis-OP-hemodialysis/composite (revenue code0821)
22 = Hemodialysis-OP-home supplies (revenue code 0822)
23 = Hemodialysis-OP-home equipment (revenue code 0823)
24 = Hemodialysis-OP-maintenance/100% (revenue code 0824)
25 = Hemodialysis-OP-support services (revenue code 0825)
29 = Hemodialysis-OP-other (revenue code 0829)
30 = Peritoneal-OP/home-general (revenue code 0830)
31 = Peritoneal-OP/home-peritoneal/composite (revenue code 0831)
32 = Peritoneal-OP/home-home supplies (revenue code 0832)
33 = Peritoneal-OP/home-home equipment (revenue code 0833)
34 = Peritoneal-OP/home-maintenance/100% (revenue code 0834)
35 = Peritoneal-OP/home-support services (revenue code 0835)

39 = Peritoneal-OP/home-other (revenue code 0839)
40 = Continuous Ambulatory Peritoneal Dialysis (CAPD)-OP-CAPD/general (revenue code 0840)
41 = CAPD-OP-CAPD/composite (revenue code 0841)
42 = CAPD-OP-home supplies (revenue code 0842)
43 = CAPD-OP-home equipment (revenue code 0843)
44 = CAPD-OP-maintenance/100% (revenue code 0844)
45 = CAPD-OP-support services (revenue code 0845)
49 = CAPD-OP-other (revenue code 0849)
50 = Continuous Cycling Peritoneal Dialysis (CCPD)-OP-CCPD/general (revenue code 0850)
51 = CCPD-OP-CCPD/composite (revenue code 0851)
52 = CCPD-OP-home supplies (revenue code 0852)
53 = CCPD-OP-home equipment (revenue code 0853)
54 = CCPD-OP-maintenance/100% (revenue code 0854)
55 = CCPD-OP-support services (revenue code 0855)
59 = CCPD-OP-other (revenue code 0859)
80 = Miscellaneous dialysis-general (revenue code 0880)
81 = Miscellaneous dialysis-ultrafiltration (revenue code 0881)
89 = Miscellaneous dialysis-other (revenue code 0889)
Missing/null = No ESRD setting indication

COMMENT: This field is derived from the presence of the dialysis revenue center codes (080X, 082X, 083X, 084X, 085X, and 088X) listed below on any of the claim records included in the stay.

This variable appears 5 times, where in the variable name is a value 1:5.

^ Back to TOC ^

EXPNDD_ACS_SW

LABEL: Expanded Access Switch

DESCRIPTION: This variable indicates that the service was provided as part of an expanded access (EA) approval.

SHORT NAME: EXPNDD_ACS_SW

LONG NAME: EXPNDD_ACS_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH (derived)

VALUES: Y = Yes
N = No

COMMENT: This field was new in 2021.

This field is derived when the condition code (CLM RLT COND CD) is equal to “ZB” or “90”, populate the field with a “Y”. If no “ZB” or “90” condition code, populate field with an “N”.

^ Back to TOC ^

FICARR_IDENT_NUM

LABEL: Fiscal Intermediary (FI) ID Number

DESCRIPTION: The identification of the fiscal intermediary (FI; CMS contractors which are currently known as Medicare administrative contractors [MACs]) processing the beneficiary's claims related to the stay.

SHORT NAME: FICARR

LONG NAME: FICARR_IDENT_NUM

TYPE: CHAR

LENGTH: 5

SOURCE: NCH

VALUES: XXXXX

COMMENT: This field comes from the fiscal intermediary number that is present on the first claim record included in the stay.

Different FIs are under contract with CMS at different times. Reference the CMS website for MAC Contractors (for example): https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the- MACs.html

^ Back to TOC ^

FINL_STD_AMT

LABEL: Final Standard Payment Amount

DESCRIPTION: This amount further adjusts the standard Medicare Payment amount (field called PPS_STD_VAL_PMT_AMT) by applying additional standardization requirements (e.g., sequestration).

SHORT NAME: FINL_STD_AMT

LONG NAME: FINL_STD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

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 go to the hospitals.

This field is new in October 2014. This field only applies to Inpatient claims.

^ Back to TOC ^

GENE_THRPY_DRUGS_TOT_AMT

LABEL: Gene Therapy Drugs Total Charge Amount

DESCRIPTION: This field contains the total charge amount for gene therapy drugs.

SHORT NAME: GENE_THRPY_DRUGS_TOT_AMT

LONG NAME: GENE_THRPY_DRUGS_TOT_AMT

TYPE: NUM

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0892 from all claim records included in the stay.

0892 = Special Processed Drugs — FDA Approved Gene Therapy (eff. 4/2020)

^ Back to TOC ^

GHO_PD_CD

LABEL: Code indicating whether Group Health Organization (GHO) has paid provider for claim(s)

DESCRIPTION: The code indicating whether a group health organization (GHO; also known as a managed care organization) has paid the provider for the claim(s).

SHORT NAME: GHOPDCD

LONG NAME: GHO_PD_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 1 = Yes, paid by GHO/MCO
Null/missing = Not paid by GHO/MCO

COMMENT: This field comes from the GHO-paid (aka MCO paid) indicator that is present on the first claim record included in the stay.

^ Back to TOC ^

HAC_PGM_RDCTN_IND_SW

LABEL: Hospital Acquired Conditions (HAC) Program Reduction Indicator

DESCRIPTION: This field is an indicator that there is reduction in payment amount from the IPPS payment for hospitals that rank in the lowest-performing quartile of selected Hospital Acquired Conditions (HAC).

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
Null/missing

COMMENT: This field identifies hospitals subject to a Hospital Acquired Condition (HAC) reduction of what they would otherwise be paid under IPPS.

The dollar amount of the reduction is in the HAC Reduction Payment Amount field (HAC_RDCTN_PMT_AMT; in 2014 it was referred to as the IPPS_FLEX_PYMT_6_AMT).

This field is new in October 2014. It is not populated (through 2018). This field only applies to Inpatient/SNF claims.

^ Back to TOC ^

HAC_RDCTN_PMT_AMT

LABEL: Hospital Acquired Conditions (HAC) Reduction Payment Amount

DESCRIPTION: This field identifies the reduction in payment amount from the IPPS payment for hospitals that rank in the lowest-performing quartile of selected Hospital Acquired Conditions (HAC).

SHORT NAME: HAC_RDCTN_PMT_AMT

LONG NAME: HAC_RDCTN_PMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: 0, -XXX (negative integers)

COMMENT: This field is derived by accumulating the HAC Reduction Payment Amount (HAC-RDCTN_PMT_AMT; in 2014 it was referred to as the IPPS_FLEX_PYMT_6_AMT) that is present on any of the claim records included in the stay (i.e., the sum of the claim HAC reduction payment amounts reported on the claims that comprise the stay).

This field is new in October 2014. This field only applies to Inpatient/SNF claims.

^ Back to TOC ^

HOSP_AT_HOME_CHRG_AMT

LABEL: Hospital at Home Room and Board (R&B) Charge Amount

DESCRIPTION: This variable represents the charge amount for room and board hospital at home care, related to a beneficiary's acute hospital at home stay.

SHORT NAME: HOSP_AT_HOME_CHRG_AMT

LONG NAME: HOSP_AT_HOME_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH (derived)

VALUES: —

COMMENT: This field was new in 2021.

This field is derived by accumulating the revenue center total charge amount associated with the revenue center code 0161 from all claim records included in the stay.

^ Back to TOC ^

HOSP_AT_HOME_FROM_DT

LABEL: Hospital at Home Care from Date

DESCRIPTION: This variable represents the beginning date of the beneficiary's acute hospital at home care stay.

SHORT NAME: HOSP_AT_HOME_FROM_DT

LONG NAME: HOSP_AT_HOME_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH (derived)

VALUES: —

COMMENT: This field was new in 2021.

This field is derived when the occurrence span code (CLM_OCRNC_SPAN_CD) is equal to "82" on any of the claim records included in the stay, populate the date in (CLM_OCRNC_SPAN_FROM_DT) to this field. If more than one record has an occurrence span code equal to "82", with different span dates, the date from the last claim record included in the stay is used.

^ Back to TOC ^

HOSP_AT_HOME_THRU_DT

LABEL: Hospital at Home Care Through Date

DESCRIPTION: This variable represents the ending date of the beneficiary's acute hospital at home care stay.

SHORT NAME: HOSP_AT_HOME_THRU_DT

LONG NAME: HOSP_AT_HOME_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH (derived)

VALUES: —

COMMENT: This field was new in 2021.

This field is derived when the occurrence span code (CLM_OCRNC_SPAN_CD) is equal to "82" on any of the claim records included in the stay, populate the date in (CLM_OCRNC_SPAN_THRU_DT) to this field. If more than one record has an occurrence span code equal to "82", with different span dates, the date from the last claim record included in the stay is used.

^ Back to TOC ^

HRR_ADJSTMT_AMT

LABEL: Hospital Readmission Reduction (HRR) Adjustment Amount

DESCRIPTION: The amount field (rounded to whole dollars) that represents the Hospital Readmission Reduction (HRR) Program amount. This is a reduction to the claim for readmissions. This field holds a negative amount.

SHORT NAME: HRR_ADJSTMT_AMT

LONG NAME: HRR_ADJSTMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: 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

This field is derived by accumulating the Claim inpatient prospective payment system (IPPS) HRR adjustment amount (previously referred to as the Flex Payment 4 Amount field: CLM_ IPPS_FLEX_PMT_4_AMT) that is present on any of the claim records included in the stay.

This field is new in 2013.

^ Back to TOC ^

HRR_ADJSTMT_PCT

LABEL: Hospital Readmission Reduction (HRR) Adjustment Percent

DESCRIPTION: The percent used to identify the readmission adjustment factor that will be applied in determining the payment amount for the Hospital Readmission Reduction (HRR) Program.

SHORT NAME: HRR_ADJSTMT_PCT

LONG NAME: HRR_ADJSTMT_PCT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: X.XXXXX

COMMENT: For payment policies, reference the Affordable Care Act (ACA) Section 3025.

The Hospital Readmission Reduction (HRR) Program applies to 'subsection (d) hospital's operating inpatient prospective payment system (IPPS) payment amount.

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

This field comes from the Claim HRR Adjustment Percent (CLM-HRR-ADJSTMT-PCT) that is present on the last claim record included in the stay.

This field is new in 2011.

^ Back to TOC ^

HRR_PRTCPNT_IND_CD

LABEL: Hospital Readmission Reduction (HRR) Participant Indicator Code

DESCRIPTION: The code used to identify whether the facility is participating in the Hospital Readmission Reduction (HRR) Program.

SHORT NAME: HRR_PRTCPNT_IND_CD

LONG NAME: 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

COMMENT: 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

This field comes from the Claim HRR Participant Indicator code (CLM-HRR-PRTCPNT-IND-CD) that is present on the first claim record included in the stay. If there is no Claim HRR Participant Indicator code on the first claim, then the first found code on any of the other claims that make up the stay is used.

This field is new in 2012.

^ Back to TOC ^

ICU_IND_CD

LABEL: Intensive Care Unit (ICU) Indicator Code

DESCRIPTION: The code indicating that the beneficiary has spent time in the intensive care unit (ICU) during the stay. It also specifies the type of ICU.

SHORT NAME: ICUINDCD

LONG NAME: ICU_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES:
0 = General (revenue center 0200)
1 = Surgical (revenue center 0201)
2 = Medical (revenue center 0202)
3 = Pediatric (revenue center 0203)
4 = Psychiatric (revenue center 0204)
6 = Intermediate IOU; (revenue center 0209) prior to 12/96 update was 'post ICU'
7 = Burn care (revenue center 0207)
8 = Trauma (revenue center 0208)
9 = Other intensive care (revenue code 0209)

COMMENT: This field is derived by checking for the presence of ICU revenue center codes (listed below) on any of the claim records included in the stay. If more than one of the revenue center codes listed below are included on these claims; the code with the highest revenue center total charge amount is used.

This field is derived by identifying the accommodation revenue center codes 020X (all nine subcategories) from all claims included in the stay.

There is approximately a 20% error rate in the revenue center code category 0206 due to coders misunderstanding the term 'post ICU' as including any day after an ICU stay rather than just days in a step-down/lower case version of an ICU. 'Post' was removed from the revenue center code 0206 description, effective 10/1/96 (12/96 MEDPAR update). 0206 Is now defined as intermediate ICU'.

^ Back to TOC ^

IME_AMT

LABEL: Indirect Medical Education (IME) Amount ($)

DESCRIPTION: The amount of additional payment (rounded to whole dollars) made to teaching hospitals for Indirect Medical Education (IME) for the stay.

SHORT NAME: IME_AMT

LONG NAME: IME_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the value amount associated with value code = 18 that is present on any of the claim records included in the stay (i.e., the sum of value code 18 amounts reported on the claims that comprise the stay).

This amount is already included in the MEDPAR Medicare payment amount (field called PMT_AMT).

^ Back to TOC ^

INCDNT_DGNSTC_SRVCS_AMT

LABEL: Medical/Surgical Supplies Incident Diagnostic Services Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical supplies incident to other diagnostic services related to the beneficiary's stay.

SHORT NAME: INCDNT_DGNSTC_SRVCS_AMT

LONG NAME: INCDNT_DGNSTC_SRVCS_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0622' from all claim records included in the stay.

This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

INCDNT_RDLGY_AMT

LABEL: Medical/Surgical Supplies Incident Radiology Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical supplies incident to radiology related to the beneficiary's stay.

SHORT NAME: INCDNT_RDLGY_AMT

LONG NAME: INCDNT_RDLGY_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0621' from all claim records included in the stay.

^ Back to TOC ^

INFRMTL_ENCTR_IND_SW

LABEL: Informational Encounter Indicator

DESCRIPTION: The indicator switch used to identify if a beneficiary is enrolled in a Managed Care Organization (MCO).

SHORT NAME: INFRMTL_ENCTR_IND_SW

LONG NAME: INFRMTL_ENCTR_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes, beneficiary is a Managed care enrollee (hospital expects to receive payment from an MCO)
N = No, beneficiary is not a MCO enrollee

COMMENT: If any claim that comprises the Stay has a condition code (CLM_RLT_COND_CD) equal to '04' populate the MEDPAR Informational Encounter Switch with a 'Y'. If no '04' condition code, populate field with an 'N'. This field is new in 2011.

^ Back to TOC ^

INHLTN_THRPY_CHRG_AMT

LABEL: Inhalation Therapy Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for inhalation therapy services (respiratory and pulmonary function) provided during the beneficiary's stay.

SHORT NAME: INHLTAMT

LONG NAME: INHLTN_THRPY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 041x and 0467x from all claim records included in the stay.

^ Back to TOC ^

INTNSV_CARE_CHRG_AMT

LABEL: Intensive Care Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for intensive care (ICU) accommodations related to a beneficiary's stay.

SHORT NAME: ICAREAMT

LONG NAME: INTNSV_CARE_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 020x from all claim records included in the stay.

^ Back to TOC ^

INTNSV_CARE_DAY_CNT

LABEL: Intensive Care Day Count

DESCRIPTION: The count of the number of intensive care unit (ICU) days used by the beneficiary for the stay.

SHORT NAME: ICARECNT

LONG NAME: INTNSV_CARE_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 020X (all 9 subcategories) from all claims included in the stay.

There is approximately a 20% error rate in the revenue center code category 0206 due to coders misunderstanding the term 'post ICU' as including any day after an ICU stay rather than just days in a step-down/lower case version of an ICU. 'Post' was removed from the revenue center code 0206 description, effective 10/1/96 (12/96 MEDPAR update). 0206 Is now defined as intermediate ICU'.

^ Back to TOC ^

INTRAOCULAR_LENS_AMT

LABEL: Medical/Surgical Supplies Intraocular Lens Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical supplies for an intraocular lens related to the beneficiary's stay.

SHORT NAME: INTRAOCULAR_LENS_AMT

LONG NAME: INTRAOCULAR_LENS_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0276' from all claim records included in the stay.

^ Back to TOC ^

INTRNL_USE_FIL_DT_CD

LABEL: For internal use only. Fiscal year/calendar year segments.

DESCRIPTION: MEDPAR Internal Use File Date Code. Limited availability; for internal use only to identify fiscal year/calendar year segments. Where not available, this field will contain a zero.

SHORT NAME: FILDTCD

LONG NAME: INTRNL_USE_FIL_DT_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0

COMMENT: —

^ Back to TOC ^

INTRNL_USE_IPSB_CD

LABEL: For internal Use Only. IPSB Code

DESCRIPTION: MEDPAR Internal Use (By IPSB) Code. Limited availability; for internal use only. Where not available, this field will contain zeroes.

SHORT NAME: IPSBCD

LONG NAME: INTRNL_USE_IPSB_CD

TYPE: CHAR

LENGTH: 3

SOURCE: MedPAR (derived)

VALUES: 000

COMMENT: —

^ Back to TOC ^

INTRNL_USE_SMPL_SIZE_CD

LABEL: For internal use. MEDPAR sample size.

DESCRIPTION: MEDPAR Internal Use Sample Size Code Limited availability; for internal use only to identify the MEDPAR sample size: 20% (HIC 9th digit = 0, 5); 20% (HIC 9th digit = 4, 8; 60% (remainder). Where not available, this field will contain a zero.

SHORT NAME: SMPLSIZE

LONG NAME: INTRNL_USE_SMPL_SIZE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0-9

COMMENT: —

^ Back to TOC ^

INTRNL_USE_SSI_DATA

LABEL: Internal Use SSI Data

DESCRIPTION: Internal Use SSI Data.

SHORT NAME: INTRNL_USE_SSI_DATA

LONG NAME: INTRNL_USE_SSI_DATA

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = information not available
Null/missing

COMMENT: Limited availability; for internal use only; applicable to inpatient claims only. Where not available, this field is will contain zeroes.

It is not populated (through 2018).

^ Back to TOC ^

INTRNL_USE_SSI_DAY_CNT

LABEL: MEDPAR Internal Use SSI Day Count

DESCRIPTION: Internal use SSI Day count.

SHORT NAME: SSIDAY

LONG NAME: INTRNL_USE_SSI_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: 0 = information not available

COMMENT: Limited availability; for internal use; applicable to inpatient claims only. Where not available, this field will contain zeroes.

^ Back to TOC ^

INTRNL_USE_SSI_IND_CD

LABEL: MEDPAR Internal Use SSI Indicator Code

DESCRIPTION: Internal use SSI Indicator code.

SHORT NAME: SSICD

LONG NAME: INTRNL_USE_SSI_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 1-9, B-X, a-z, #, @, >
null/missing

COMMENT: Limited availability; for internal use only; applicable to inpatient claims only. Where not available, this field is set to null/missing.

^ Back to TOC ^

INVSTGTNL_DVC_AMT

LABEL: Medical/Surgical Supplies Investigational Device Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical investigational devices supplies related to the beneficiary's stay.

SHORT NAME: INVSTGTNL_DVC_AMT

LONG NAME: INVSTGTNL_DVC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0624' from all claim records included in the stay.

This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

IP_ADMSN_TYPE_CD

LABEL: Inpatient Admission Type Code

DESCRIPTION: The code indicating the type and priority of the beneficiary's admission to a facility for the Inpatient hospital stay.

SHORT NAME: TYPE_ADM

LONG NAME: 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 because 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: This field comes from the source Inpatient admission type code that is present on the last claim record included in the stay.

^ Back to TOC ^

IP_DSPRPRTNT_SHR_AMT

LABEL: Inpatient Disproportionate Share (DSH) Amount ($)

DESCRIPTION: The amount paid over the DRG amount (rounded to whole dollars) for the disproportionate share hospital (DSH) for the stay.

SHORT NAME: DISP_SHR

LONG NAME: IP_DSPRPRTNT_SHR_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the value amount associated with value code = 18 that is present on any of the claim records included in the stay (i.e., the sum of value code 18 amounts reported on the claims that comprise the stay).

This amount is already included in the MEDPAR Medicare payment amount (field called PMT_AMT).

^ Back to TOC ^

IP_LOW_VOL_PYMT_AMT

LABEL: Inpatient Low Volume Payment Amount

DESCRIPTION: 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: IP_LOW_VOL_PYMT_AMT

LONG NAME: IP_LOW_VOL_PYMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the IP Low Volume Amount that is present on any of the claim records included in the stay (i.e., the sum of the low volume amounts reported on the claims that comprise the stay).

^ Back to TOC ^

IPPS_FLEX_PYMT_6_AMT

LABEL: Flexible Payment Amount (6th) — renamed to Hospital Acquired Conditions (HAC) Reduction Payment Amount

DESCRIPTION: This field identifies the reduction in payment amount from the IPPS payment for hospitals that rank in the lowest-performing quartile of selected Hospital Acquired Conditions (HAC).

SHORT NAME: IPPS_FLEX_PYMT_6_AMT

LONG NAME: IPPS_FLEX_PYMT_6_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the IPPS_FLEX_PYMT_6_AMT) that is present on any of the claim records included in the stay (i.e., the sum of the claim HAC reduction payment amounts reported on the claims that comprise the stay).

This field is new in October 2014. This field only applies to Inpatient claims. Starting in 2015, the MedPAR field is renamed to HAC_RDCTN_PMT_AMT.

^ Back to TOC ^

IPPS_FLEX_PYMT_7_AMT

LABEL: Flexible Payment Amount — 7th (placeholder)

DESCRIPTION: This field is a placeholder for a dollar amount to be used for a future policy.

SHORT NAME: IPPS_FLEX_PYMT_7_AMT

LONG NAME: IPPS_FLEX_PYMT_7_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is new in October 2014 (it is not populated). This field only applies to Inpatient claims.

This field is derived by accumulating the Claim IPPS Flexible Payment 7 Amount (CLM-IPPS-FLEX-PMT-7-AMT) that is present on any of the claim records included in the stay (i.e., the sum of the claim IPPS flexible payment 7 amounts reported on the claims that comprise the stay).

^ Back to TOC ^

ISLET_ADD_ON_PYMT_AMT

LABEL: Islet Add-On Payment Amount

DESCRIPTION: This field is used to identify the Islet add-on payment amount found in the value code/amount trailer.

SHORT NAME: ISLET_ADD_ON_PYMT_AMT

LONG NAME: ISLET_ADD_ON_PYMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the claim value amount associated with Claim Value Code (CLM_VAL_CD) equal to 'Q7' from all claim records included in the stay.

This field is new in 2016.

^ Back to TOC ^

LAB_CHRG_AMT

LABEL: Laboratory Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for laboratory costs related to the beneficiary's stay.

SHORT NAME: LAB_AMT

LONG NAME: LAB_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 030x, 031x, 074x, and 075x from all claim records included in the stay.

^ Back to TOC ^

LOS_DAY_CNT

LABEL: Days of beneficiary’s stay in a hospital/SNF

DESCRIPTION: The count in days of the total length of a beneficiary's stay in a hospital or SNF.

SHORT NAME: LOSCNT

LONG NAME: LOS_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by subtracting the date of discharge (or thru date in SNF cases where beneficiary is still a patient) from the date of admission. If difference is '0,' the value becomes a '1.'

^ Back to TOC ^

LTCH_DPP_ADJSTMT_AMT

LABEL: Long-Term Care Hospital Discharge Payment Percentage Adjustment Amount

DESCRIPTION: The sum of the CLM_LTCH_DSCHRG_PMT_PCT_AMT reported on the claims that comprised the stay.

SHORT NAME: LTCH_DPP_ADJSTMT_AMT

LONG NAME: LTCH_DPP_ADJSTMT_AMT

TYPE: NUM

LENGTH: 10

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the Claim LTCH Discharge Payment Percentage Adjustment Amount (CLM_LTCH_DSCHRG_PMT_PCT_AMT) that is present in any of the claim records included in the stay.

^ Back to TOC ^

LTHTRPSY_CHRG_AMT

LABEL: Lithotripsy Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for lithotripsy services provided during the beneficiary's stay.

SHORT NAME: LTHTRPSY

LONG NAME: LTHTRPSY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 079X from all claim records included in the stay.

^ Back to TOC ^

LTST_CLM_ACRTN_DT

LABEL: Latest Claim Accretion Date

DESCRIPTION: The date the latest claim record included in the stay was accreted (posted/processed) to the master record at the CWF host.

SHORT NAME: ACRTNDT

LONG NAME: LTST_CLM_ACRTN_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the highest accretion date that is present on the claim records included in the stay.

^ Back to TOC ^

MA_TCHNG_IND_SW

LABEL: MA Teaching Indicator

DESCRIPTION: The code used to identify whether the claim contains any request for supplemental Indirect Medical Education (IME)/Graduate Medical Education (DGME)/Nursing and Allied Health (N&AH) payment.

SHORT NAME: MA_TCHNG_IND_SW

LONG NAME: MA_TCHNG_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes, provider requests a supplemental payment for IME/DGME/N&AH
N = No additional IME/DGME/N&AH payment requested

COMMENT: If any claim that comprises the Stay has a condition code (CLM-RLT-COND-CD) equal to '69' populate the MEDPAR MA Teaching Indicator Switch with a 'Y'. If no '69' condition code, populate field with an 'N'. This field is new in 2011.

^ Back to TOC ^

MDCL_SRGCL_DRSNG_AMT

LABEL: Medical/Surgical Dressing Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical dressing supplies related to the beneficiary's stay.

SHORT NAME: MDCL_SRGCL_DRSNG_AMT

LONG NAME: MDCL_SRGCL_DRSNG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0623' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

MDCL_SRGCL_GNRL_AMT

LABEL: Medical/ Surgical General Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical general supplies related to the beneficiary's stay.

SHORT NAME: MDCL_SRGCL_GNRL_AMT

LONG NAME: MDCL_SRGCL_GNRL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0270' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

MDCL_SRGCL_MISC_AMT

LABEL: Medical/Surgical Miscellaneous Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical miscellaneous supplies related to the beneficiary's stay.

SHORT NAME: MDCL_SRGCL_MISC_AMT

LONG NAME: MDCL_SRGCL_MISC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0621', '0622', '0623', '0624' from all claim records included in the stay.

This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

MDCL_SRGCL_NSTRL_AMT

LABEL: Medical/Surgical Non-Sterile Supplies Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical non-sterile supplies related to the beneficiary's stay.

SHORT NAME: MDCL_SRGCL_NSTRL_AMT

LONG NAME: MDCL_SRGCL_NSTRL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0271' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

MDCL_SRGCL_PCMKR_AMT

LABEL: Medical/Surgical Pacemaker Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical pacemaker supplies related to the beneficiary's stay.

SHORT NAME: MDCL_SRGCL_PCMKR_AMT

LONG NAME: MDCL_SRGCL_PCMKR_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: -

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0275' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

MDCL_SRGCL_STRL_AMT

LABEL: Medical/Surgical Sterile Supplies Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical sterile supplies related to the beneficiary's stay.

SHORT NAME: MDCL_SRGCL_STRL_AMT

LONG NAME: MDCL_SRGCL_STRL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0272' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

MDCL_SUPLY_CHRG_AMT

LABEL: Medical/Surgical Supplies Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for medical/surgical supplies related to the beneficiary's stay.

SHORT NAME: SUPLYAMT

LONG NAME: MDCL_SUPLY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 027x, and 062x from all claim's records included in the stay.

Note that detailed revenue center charge amounts for medical/surgical supplies are available 2011 forward — reference the following 12 fields: MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, and OTHR_SUPLIES_DVC_AMT.

^ Back to TOC ^

MDCR_PMT_AMT

LABEL: Total Medicare Payment Amount ($)

DESCRIPTION: Amount of payment made from the Medicare trust fund for the services covered by the claim record.

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 stay, the pass-through amount (which is the daily per diem amount; field called PASSTHRU) must be added to this field.

SHORT NAME: PMT_AMT

LONG NAME: MDCR_PMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

COMMENT: This field is derived by accumulating the payment amount that is present on all the claim records included in the stay (i.e., the sum of payment [reimbursement] reported on the claims that comprise the stay).

In some situations, a negative claim payment amount may be present. For example:

1. when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or
2. when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, Inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (DSH), in-direct medical education (IME), and total PPS capital.

It does not include the pass thru per diem amounts (i.e., capital-related direct medical education costs, kidney acquisition deductibles and coinsurance), or any other payer reimbursement.

Under SNF PPS, services are paid using the patient classification system known as RUGs III.

For the SNF PPS claim, the rate for each revenue center line item with revenue center code = '0022' is used; MEDPAR multiplies the rate times the units count; and then sums the amount payable for all lines with revenue center code '0022' to determine the total Medicare payment amount.

For demo ids '01','02','03','04' — claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo ids '05','15' — encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo ids '06','07','08' — claims contain actual provider payment but represent a special negotiated bundled payment for both part A and part B services. To identify what the conventional provider part a payment would have been, check value code = 'y4'.

For BBA encounter data (non-demo) — 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

^ Back to TOC ^

MEDPAR_ID

LABEL: MEDPAR ID Number

DESCRIPTION: Unique key for MEDPAR claim.

SHORT NAME: MEDPARID

LONG NAME: MEDPAR_ID

TYPE: CHAR

LENGTH: 15

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: —

^ Back to TOC ^

MEDPAR_YR_NUM

LABEL: Year of MedPAR Record

DESCRIPTION: Year of the MEDPAR record.

SHORT NAME: MEDPAR_YR_NUM

LONG NAME: MEDPAR_YR_NUM

TYPE: CHAR

LENGTH: 4

SOURCE: MedPAR (derived)

VALUES: 1999 +

COMMENT: —

^ Back to TOC ^

MRI_CHRG_AMT

LABEL: Magnetic Resonance Imaging (MRI) charge amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for magnetic resonance imaging (MRI) services provided during the beneficiary's stay.

SHORT NAME: MRI_AMT

LONG NAME: MRI_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center 061x from all claim records included in the stay.

^ Back to TOC ^

NCH_CLM_TYPE_CD

LABEL: NCH Claim Type Code

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

SHORT NAME: CLM_TYPE

LONG NAME: NCH_CLM_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: NCH

VALUES:
20 = Medicare Non-Swing Bed Skilled Nursing Facility (SNF) Claim
30 = Medicare Swing Bed SNF Claim
60 = Medicare Inpatient Claim
61 = Medicare Inpatient Full Encounter Claim
62 = Medicare Advantage Indirect Medical Education (IME)/Graduate Medical Education (GME) Claims
63 = Medicare Advantage (No-Pay) Claims
64 = Medicare Advantage (Paid as fee-for-service) Claims

COMMENT: —

^ Back to TOC ^

NEW_TCHNLGY_ADD_ON_AMT

LABEL: New Technology Add on Amount

DESCRIPTION: The amount of payments made for discharges involving approved new technologies.

SHORT NAME: NEW_TCHNLGY_ADD_ON_AMT

LONG NAME: NEW_TCHNLGY_ADD_ON_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field was new in 2011.

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.

This field is derived by accumulating the amount field (CLM-VAL-AMT) found in the value code trailer for value code (CLM-VAL-CD) equal to '77' for any claim records included in the stay.

^ Back to TOC ^

NO_PSTV_TEST_SW

LABEL: No Positive Test Switch

DESCRIPTION: This variable indicates that a positive test result is not included in the patient's medical records.

SHORT NAME: NO_PSTV_TEST_SW

LONG NAME: NO_PSTV_TEST_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH (derived)

VALUES: Y = Yes
N = No

COMMENT: This field was new in 2021.

This field is derived when the condition code (CLM RLT COND CD) is equal to "ZA", populate the field with a "Y". If no "ZA" condition code, populate field with an "N".

^ Back to TOC ^

OBSRVTN_SW

LABEL: Observation Unit Indicator

DESCRIPTION: The switch used to identify whether the claim involves treatment or observation in an observation unit.

SHORT NAME: OBSRVTN_SW

LONG NAME: OBSRVTN_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes, claim included services in an observation unit
N = No observation unit services.

COMMENT: If any claim that comprises the Stay has a revenue center code (REV-CNTR-CD) equal to '0762' then MEDPAR Observation Switch = 'Y'. If no '0762' revenue center code, then field ='N'.

This field is new in 2011.

^ Back to TOC ^

OCPTNL_THRPY_CHRG_AMT

LABEL: Occupational Therapy Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for occupational therapy services provided during the beneficiary's stay.

SHORT NAME: OCPTLAMT

LONG NAME: OCPTNL_THRPY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 043X from all claim records included in the stay.

^ Back to TOC ^

OP_SRVC_CHRG_AMT

LABEL: Outpatient Service Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for out-patient services provided during the beneficiary's stay.

SHORT NAME: OPSRVC

LONG NAME: OP_SRVC_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 049x and 050x from all claim records included in the stay.

^ Back to TOC ^

OP_SRVC_IND_CD

LABEL: Outpatient services/ambulatory surgical care indicator code

DESCRIPTION: The code indicating whether the beneficiary has received outpatient services, ambulatory surgical care, or both.

SHORT NAME: OPSRVCCD

LONG NAME: OP_SRVC_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = No outpatient services/ambulatory surgical care (revenue code other than 049X, 050X)
1 = Outpatient services (revenue code 050X)
2 = Ambulatory surgical care (revenue code 049X)
3 = Outpatient services and ambulatory surgical care (revenue codes 049X and 050X)

COMMENT: This field is derived by checking for the presence of the outpatient services revenue center codes (049X, 050X) on any of the claim records included in the stay.

^ Back to TOC ^

OPRTG_HSP_AMT

LABEL: Operating Hospital Amount

DESCRIPTION: The sum of the claim operating HSP amounts reported on the claims that comprise the stay. The operating HSP amount is used to identify the difference between the HSP rate payment (updated HSP x DRG weight) and the federal rate payment (includes DSH, IME, outliers, etc. as applicable) when HSP rate payment exceeds Federal rate payment (otherwise $0).

SHORT NAME: OPRTG_HSP_AMT

LONG NAME: OPRTG_HSP_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field was new in 2011.

This field is derived by accumulating the Claim Operating HSP Amount (CLM_OPRTG_HSP_AMT) that is present on any of the claim records included in the stay (i.e., of the claim operating HSP amounts reported on the claims that comprise the stay).

^ Back to TOC ^

OPRTG_ROOM_AMT

LABEL: Operating and Recovery Room Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the operating room and recovery room related to the beneficiary's stay.

SHORT NAME: OPRTG_ROOM_AMT

LONG NAME: OPRTG_ROOM_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0360', '0361', '0362', '0363', '0364', '0365', '0366', '0367', '0368' and '0369', '0710', '0711', '0712', '0713', '0714', '0715', '0717', '0718' and '0719' from all claim records included in the stay.

This field was new in 2011.

Note that the sum of this field and the labor room and delivery charge amounts (OR_LABOR_DLVRY_AMT) is available all years (field called OROOMAMT).

^ Back to TOC ^

OPRTG_ROOM_CHRG_AMT

LABEL: Operating Room Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the operating room, recovery room, and labor delivery room used by the beneficiary during the stay.

SHORT NAME: OROOMAMT

LONG NAME: OPRTG_ROOM_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 036X, 071X, and 072X from all claim records included in the stay.

^ Back to TOC ^

OR_LABOR_DLVRY_AMT

LABEL: Labor Room and Delivery Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the labor room and delivery related to the beneficiary's stay.

SHORT NAME: OR_LABOR_DLVRY_AMT

LONG NAME: OR_LABOR_DLVRY_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0720', '0721', '0722', '0723', '0724', '0725', '0726', '0727', '0728' and '0729' from all claim records included in the stay. This field was new in 2011.

Note that the sum of this field and the operating room charge amounts (OPRTG_ROOM_AMT) is available all years (field called OROOMAMT).

^ Back to TOC ^

ORG_NPI_NUM

LABEL: Organization NPI Number

DESCRIPTION: The National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

SHORT NAME: ORGNPINM

LONG NAME: ORG_NPI_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the organization NPI that is present on the first claim record included in the stay.

^ Back to TOC ^

ORGN_ACQSTN_CHRG_AMT

LABEL: Organ acquisition or other donor bank charge amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for organ acquisition or other donor bank services related to a beneficiary's stay.

SHORT NAME: ORGNAMT

LONG NAME: ORGN_ACQSTN_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 081x and 089x from all claim records included in the stay.

^ Back to TOC ^

ORGN_ACQSTN_IND_CD

LABEL: Organ Acquisition Type Code

DESCRIPTION: The code indicating the type of organ acquisition received by the beneficiary during the stay.

SHORT NAME: ORGNCD

LONG NAME: ORGN_ACQSTN_IND_CD

TYPE: CHAR

LENGTH: 2

SOURCE: MedPAR (derived)

VALUES:
K1 = General classification (revenue code 0810)
K2 = Living donor kidney (revenue code 0811)
K3 = Cadaver donor kidney (revenue code 0812)
K4 = Unknown donor kidney (revenue code 0813)
K5 = Other kidney acquisition (revenue code 0814)
H1 = Cadaver donor heart (revenue code 0815)
H2 = Other heart acquisition (revenue code 0816)
L1 = Donor liver (revenue code 0817)
01 = Other organ acquisition (revenue code 0819)
02 = General acquisition (revenue code 0890)
B1 = Bone donor bank (revenue code 0891)
03 = Organ donor bank other than kidney (revenue code 0892)
S1 = Skin donor bank (revenue code 0893)
04 = Other donor bank (revenue code 0899)
Null/Missing = No organ acquisition indication

COMMENT: This field is derived by checking for the presence of the organ acquisition revenue center codes (081x and 089x) on any of the claim records included in the stay.

^ Back to TOC ^

OTHR_IMPLANTS_AMT

LABEL: Medical/Surgical Supplies Other Implants Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical other implant supplies related to the beneficiary's stay.

SHORT NAME: OTHR_IMPLANTS_AMT

LONG NAME: OTHR_IMPLANTS_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0278' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

OTHR_SRVC_CHRG_AMT

LABEL: Other Services Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for other services (revenue centers that do not fit into other categories) related to a beneficiary's stay.

SHORT NAME: OTHRAMT

LONG NAME: OTHR_SRVC_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with the 'other' revenue center codes from all claim records included in the stay. The 'other' codes include 0002–0099, 022x, 023x, 024x, 052x, 053x, 055x–060x, 064x–070x, 076x–078x,090x–095x, and 099x.

^ Back to TOC ^

OTHR_SUPLIES_DVC_AMT

LABEL: Medical/Surgical Supplies Other Device Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical supplies for other devices related to the beneficiary's stay.

SHORT NAME: OTHR_SUPLIES_DVC_AMT

LONG NAME: OTHR_SUPLIES_DVC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0279' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

OUTLIER_DAY_CNT

LABEL: Days paid as outliers (either day or cost) under PPS beyond DRG threshold

DESCRIPTION: The count of the number of days paid as outliers (either a day or cost outlier) under PPS beyond the DRG threshold.

SHORT NAME: OUTLRDAY

LONG NAME: OUTLIER_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by checking the MEDPAR utilization day count against the DRG threshold table (DRG weights file).

^ Back to TOC ^

OXYGN_TAKE_HOME_AMT

LABEL: Medical/Surgical Supplies Oxygen Take Home Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical oxygen take home supplies related to the beneficiary's stay.

SHORT NAME: OXYGN_TAKE_HOME_AMT

LONG NAME: OXYGN_TAKE_HOME_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0277' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

PA_IND_CD

LABEL: Prior Authorization Indicator Code

DESCRIPTION: This field identifies the indicator assigned by CMS for each prior authorization program to define the applicable line of business i.e., Part A, Part B, DME, Home Health and Hospice.

SHORT NAME: PA_IND_CD

LONG NAME: PA_IND_CD

TYPE: CHAR

LENGTH: 4

SOURCE: NCH

VALUES: The value is a four-digit alpha-numeric code, where the first digit is:

A = Part A
B = Part B
D = DME
H = Home Health and Hospice
Followed by a three-digit number (e.g., A123)
Null/missing

COMMENT: This field comes from the Prior Authorization Indicator Code (CLM-PRIOR-AUTHRZ-IND-SW) that is present on the first claim record included in the stay. If there is no prior authorization indicator switch on the 1st claim record, then take the first found code on any of the other claims that make up the stay.

This field is new in October 2014 (not populated through 2018).

^ Back to TOC ^

PASS_THRU_AMT

LABEL: Pass Thru Per Diem Amount for Stay ($)

DESCRIPTION: The total of all claim pass through per diem amounts (rounded to whole dollars) for the stay.

SHORT NAME: PASSTHRU

LONG NAME: PASS_THRU_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by multiplying the pass thru per diem amount that is present on the last claim record included in the stay times the MEDPAR utilization day count (the sum of the utilization [covered] days reported on the claims that comprise the stay).

Items reimbursed as pass through include capital-related costs, direct medical education costs, kidney acquisition costs for hospitals approved as rtc's, and bad debts (per provider reimbursement manual, part 1, section 2405.2).

This MEDPAR pass thru amount is not included in the MEDPAR Medicare payment amount (i.e., to obtain total payments, the pass thru per diem must be added to the total payment amount — field called PMT_AMT).

^ Back to TOC ^

PGM_RDCTN_IND_SW

LABEL: Electronic Health Records (EHR) Program Reduction Indicator

DESCRIPTION: This field is a switch that identifies which hospitals are Electronic Health Records (EHR) meaningful users.

SHORT NAME: PGM_RDCTN_IND_SW

LONG NAME: 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.

^ Back to TOC ^

PHRMCY_CHRG_AMT

LABEL: Pharmacy Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for pharmaceutical costs related to the beneficiary's stay.

SHORT NAME: PHRMCAMT

LONG NAME: PHRMCY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 025x, 026x, and 063x from all claim's records included in the stay.

^ Back to TOC ^

PHRMCY_IND_CD

LABEL: Pharmacy Indicator Code

DESCRIPTION: The code indicating whether the beneficiary received drugs during the stay. It also specifies the type of drugs.

SHORT NAME: PHRMCYCD

LONG NAME: PHRMCY_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES:
0 = No drugs (revenue code other than those listed below)
1 = General drugs and/pr IV therapy (revenue code 025x, 026x)
2 = Erythropoietin (epoetin: revenue code 0630, 0635, 0637, 0639)
3 = Blood clotting drugs (revenue code 0636)
4 = General drugs and/or IV therapy; and epoetin (combination of values 1 and 2)
5 = General drugs and/or IV therapy; and blood clotting drugs (combination of values 1 and 3)

COMMENT: This field is derived by checking for the presence of drug-specific revenue center codes (025x, 026x, and 063x) on any of the claim records included in the stay.

^ Back to TOC ^

PHYS_THRPY_CHRG_AMT

LABEL: Physical Therapy Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for physical therapy services provided during the beneficiary's stay.

NOTE: Effective with MEDPAR2000 expansion, all amount fields were expanded from S9(7) to S9(9).

SHORT NAME: PHYTHAMT

LONG NAME: PHYS_THRPY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 042X from all claim records included in the stay.

^ Back to TOC ^

POA_DGNS_1_IND_CD

POA_DGNS_2_IND_CD

POA_DGNS_3_IND_CD

POA_DGNS_4_IND_CD

POA_DGNS_5_IND_CD

POA_DGNS_6_IND_CD

POA_DGNS_7_IND_CD

POA_DGNS_8_IND_CD

POA_DGNS_9_IND_CD

POA_DGNS_10_IND_CD

POA_DGNS_11_IND_CD

POA_DGNS_12_IND_CD

POA_DGNS_13_IND_CD

POA_DGNS_14_IND_CD

POA_DGNS_15_IND_CD

POA_DGNS_16_IND_CD

POA_DGNS_17_IND_CD

POA_DGNS_18_IND_CD

POA_DGNS_19_IND_CD

POA_DGNS_20_IND_CD

POA_DGNS_21_IND_CD

POA_DGNS_22_IND_CD

POA_DGNS_23_IND_CD

POA_DGNS_24_IND_CD

POA_DGNS_25_IND_CD

LABEL: Diagnosis 1 Present on Admission (POA) Indicator Code

DESCRIPTION: The code used to identify the present on admission (POA) indicator code associated with the diagnosis codes (DGNSCD1–DGNSCD25).

SHORT NAME:

POA_DGNS_1_IND_CD
POA_DGNS_2_IND_CD
POA_DGNS_3_IND_CD
POA_DGNS_4_IND_CD
POA_DGNS_5_IND_CD
POA_DGNS_6_IND_CD
POA_DGNS_7_IND_CD
POA_DGNS_8_IND_CD
POA_DGNS_9_IND_CD
POA_DGNS_10_IND_CD
POA_DGNS_11_IND_CD
POA_DGNS_12_IND_CD
POA_DGNS_13_IND_CD
POA_DGNS_14_IND_CD
POA_DGNS_15_IND_CD
POA_DGNS_16_IND_CD
POA_DGNS_17_IND_CD
POA_DGNS_18_IND_CD
POA_DGNS_19_IND_CD
POA_DGNS_20_IND_CD
POA_DGNS_21_IND_CD
POA_DGNS_22_IND_CD
POA_DGNS_23_IND_CD
POA_DGNS_24_IND_CD
POA_DGNS_25_IND_CD

LONG NAME:

POA_DGNS_1_IND_CD
POA_DGNS_2_IND_CD
POA_DGNS_3_IND_CD
POA_DGNS_4_IND_CD
POA_DGNS_5_IND_CD
POA_DGNS_6_IND_CD
POA_DGNS_7_IND_CD
POA_DGNS_8_IND_CD
POA_DGNS_9_IND_CD
POA_DGNS_10_IND_CD
POA_DGNS_11_IND_CD
POA_DGNS_12_IND_CD
POA_DGNS_13_IND_CD
POA_DGNS_14_IND_CD
POA_DGNS_15_IND_CD
POA_DGNS_16_IND_CD
POA_DGNS_17_IND_CD
POA_DGNS_18_IND_CD
POA_DGNS_19_IND_CD
POA_DGNS_20_IND_CD
POA_DGNS_21_IND_CD
POA_DGNS_22_IND_CD
POA_DGNS_23_IND_CD
POA_DGNS_24_IND_CD
POA_DGNS_25_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = Diagnosis codes that are exempt from the POA reporting requirements (same meaning as null/missing)

1 = Unreported/not used — exempt from POA reporting — this code is equivalent to a blank on the UB-04.

Y = Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected hospital acquired conditions (HACs) that are coded as 'Y' for the POA Indicator.

N = Diagnosis was not present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'N' for the POA Indicator.

U = Documentation is insufficient to determine if the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'U' for the POA Indicator.

W = Clinically undetermined. Provider is unable to clinically determine whether condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as 'W' for the POA Indicator.

Z = Denotes the end of the POA indicators (terminated 1/2011).

X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future (terminated 1/2011).

Null/missing = Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the '1'; same meaning as '0').

COMMENT: The POA indicators for the diagnosis E codes are stored in the variables POA_DGNS_E_1_IND_CD–POA_DGNS_E_25_IND_CD.

^ Back to TOC ^

POA_DGNS_CD_CNT

LABEL: Count of Present on Admission (POA) Diagnosis Codes

DESCRIPTION: The count of the number of Present on Admission (POA) diagnosis codes reported on the Inpatient/SNF claim.

SHORT NAME: POA_DGNS_CD_CNT

LONG NAME: POA_DGNS_CD_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: 0 to 25

COMMENT: This field was new in 2009.

^ Back to TOC ^

POA_DGNS_E_1_IND_CD

POA_DGNS_E_2_IND_CD

POA_DGNS_E_3_IND_CD

POA_DGNS_E_4_IND_CD

POA_DGNS_E_5_IND_CD

POA_DGNS_E_6_IND_CD

POA_DGNS_E_7_IND_CD

POA_DGNS_E_8_IND_CD

POA_DGNS_E_9_IND_CD

POA_DGNS_E_10_IND_CD

POA_DGNS_E_11_IND_CD

POA_DGNS_E_12_IND_CD

LABEL: Diagnosis E Code Present on Admission Indicator 1

DESCRIPTION: The code used to identify the present on admission (POA) indicator code associated with the diagnosis E codes (variables called DGNS_E_1_CD–DGNS_E_12_CD).

SHORT NAME:

POA_DGNS_E_1_IND_CD
POA_DGNS_E_2_IND_CD
POA_DGNS_E_3_IND_CD
POA_DGNS_E_4_IND_CD
POA_DGNS_E_5_IND_CD
POA_DGNS_E_6_IND_CD
POA_DGNS_E_7_IND_CD
POA_DGNS_E_8_IND_CD
POA_DGNS_E_9_IND_CD
POA_DGNS_E_10_IND_CD
POA_DGNS_E_11_IND_CD
POA_DGNS_E_12_IND_CD

LONG NAME:

POA_DGNS_E_1_IND_CD
POA_DGNS_E_2_IND_CD
POA_DGNS_E_3_IND_CD
POA_DGNS_E_4_IND_CD
POA_DGNS_E_5_IND_CD
POA_DGNS_E_6_IND_CD
POA_DGNS_E_7_IND_CD
POA_DGNS_E_8_IND_CD
POA_DGNS_E_9_IND_CD
POA_DGNS_E_10_IND_CD
POA_DGNS_E_11_IND_CD
POA_DGNS_E_12_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = Diagnosis codes that are exempt from the POA reporting requirements (same meaning as null/missing)

1 = Unreported/not used — exempt from POA reporting. This code is equivalent to a blank on the UB-04.

Y = Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected hospital acquired conditions (HACs) that are coded as 'Y' for the POA Indicator.

N = Diagnosis was not present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'N' for the POA Indicator.

U = Documentation is insufficient to determine if the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'U' for the POA Indicator.

W = Clinically undetermined. Provider is unable to clinically determine whether condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as 'W' for the POA Indicator.

Z = Denotes the end of the POA indicators (terminated 1/2011).

X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future (terminated 1/2011).

Null/missing = Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the '1'; same meaning as '0').

COMMENT: The E codes are used to identify external causes of injury, poisoning, or other adverse events.

The POA indicators for the regular (non-E code diagnoses) are stored in the variables POA_DGNS_1_IND_CD–POA_DGNS_25_IND_CD.

^ Back to TOC ^

POA_DGNS_E_CD_CNT

LABEL: Count of Present on Admission (POA) Diagnosis E Codes

DESCRIPTION: The count of the number of Present on Admission (POA) codes associated with the diagnosis E codes reported on the Inpatient/SNF claim.

SHORT NAME: POA_DGNS_E_CD_CNT

LONG NAME: POA_DGNS_E_CD_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: 0 to 12

COMMENT: This field was new in 2009.

The E codes are used to identify external causes of injury, poisoning, or other adverse events.

^ Back to TOC ^

PPS_IND_CD

LABEL: Prospective payment system (PPS) Indicator Code

DESCRIPTION: The code indicating whether the facility is being paid under the prospective payment system (PPS).

SHORT NAME: PPS_IND

LONG NAME: PPS_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = facility is not PPS
2 = facility is PPS

COMMENT: This value is calculated by determining if the condition code is not equal 65 on all the claims included in the stay and the third position of the provider number is numeric, then the value of this field = 2 (PPS); otherwise, the value = 0 (non-PPS.)

^ Back to TOC ^

PPS_PRCR_VRSN _CD

LABEL: Prospective Payment System (PPS) Pricer Version

DESCRIPTION: This variable displays the prospective payment system (PPS) pricer version.

SHORT NAME: PPS_PRCR_VRSN_CD

LONG NAME: PPS_PRCR_VRSN_CD

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field was new in 2021.

^ Back to TOC ^

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: 8

SOURCE: NCH

VALUES: —

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 go to the hospitals.

This field is new in October 2014. This field only applies to Inpatient claims. Note that 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 ^

PROD_RPLCMT_LIFECYC_SW

LABEL: Product Replacement within Product Lifecycle (early)

DESCRIPTION: The switch used to identify whether a claim involves the replacement of a product earlier than the anticipated lifecycle due to an indication the product is not functioning properly.

SHORT NAME: PROD_RPLCMT_LIFECYC_SW

LONG NAME: PROD_RPLCMT_LIFECYC_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes, product replaced early/within product lifecycle
N = No, product not replaced early (or not applicable)

COMMENT: If any claim that comprises the Stay has a condition code (CLM-RLT-COND-CD) equal to '49' then the MEDPAR Product Replacement within Product Lifecycle Switch = 'Y'. If no '49' condition code, then this field ='N'.

This field is new in 2011.

^ Back to TOC ^

PROD_RPLCMT_RCLL_SW

LABEL: Product Replacement for Recall of Product

DESCRIPTION: The switch used to identify whether a claim involves the replacement of a product because of the Manufacturer or FDA having identified the product for recall and therefore a replacement.

SHORT NAME: PROD_RPLCMT_RCLL_SW

LONG NAME: PROD_RPLCMT_RCLL_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes, product recalled
N = No, product not recalled (or not applicable)

COMMENT: If any claim that comprises the Stay has a Condition code (CLM-RLT-COND-CD) equal to '50' then the MEDPAR Product Replacement Recall Switch ='Y'. If no '50' condition code, then field ='N'.

This field is new in 2011.

^ Back to TOC ^

PROFNL_FEES_CHRG_AMT

LABEL: Professional Fees Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for professional fees related to a beneficiary's stay.

SHORT NAME: PROFFEES

LONG NAME: PROFNL_FEES_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 096x, 097x, and 098x from all claim records included in the stay.

Note that additional physician fees for care during the stay may appear on the Medicare Part B (carrier) claims.

^ Back to TOC ^

PRSTHTC_ORTHTC_AMT

LABEL: Medical/Surgical Supplies Prosthetic Orthotic Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical prosthetic/orthotic devices related to the beneficiary's stay.

SHORT NAME: PRSTHTC_ORTHTC_AMT

LONG NAME: PRSTHTC_ORTHTC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0274' from all claim records included in the stay.

This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

PRVDR_NUM

LABEL: Provider Number

DESCRIPTION: This variable is the provider identification number.

The first two digits indicate the state where the provider is located, using the SSA state codes; 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: PRVDRNUM

LONG NAME: PRVDR_NUM

TYPE: CHAR

LENGTH: 10

SOURCE: NCH

VALUES: The following are the last four digits of the provider number; the blocks of numbers classify the facilities:

0001–0879	Short-term (general and specialty) hospitals where Type of bill (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
1300–1399	Critical access hospitals (CAH)
1990–1999	Religious Nonmedical Health Care Institutions (RNHCI)
2000–2299	Long-term hospitals
3025–3099	Rehabilitation hospitals
3300–3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
4000–4499	Psychiatric hospitals
5000–6499	Skilled nursing facilities

COMMENT: 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).

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. Starting in 2021, an alpha character in the third position of the provider number identifies the category of institutional provider that furnished services to the beneficiary during the stay. This applies to IPPS hospitals, critical access hospitals, and

IPPS-excluded hospitals with IPPS-excluded rehabilitation or psychiatric units or swing beds (as applicable) as follows:

U = Swing-bed hospital designation for short-term hospitals

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

Starting in 2021, the PRVDR_BASE_FAC_CCN_NUM is populated with CCN of the parent provider for IPPS hospitals, critical access hospitals, and IPPS-excluded hospitals with IPPS-excluded rehabilitation or psychiatric units or swing beds (as applicable). Beginning in 2021, the PRVDR_NUM may contain an alpha character in the third digit, which is recoded when it appears in the PRVDR_BASE _FAC_CCN_NUM as follows:

Where position 3 is an alpha character (S, T, U, W, or Y) replace with a “0”.

Where position 3 is an alpha character (M or R) replace with a “1”.

^ Back to TOC ^

PRVDR_BASE _FAC_CCN_NUM

LABEL: Provider Base Facility CMS Certification Number (CCN)

DESCRIPTION: This variable is the CMS Certification Number (CCN).

It is the CCN of the parent provider for IPPS hospitals, Critical Access Hospitals, and IPPS-Excluded hospitals with IPPS-excluded rehabilitation or psychiatric units or swing beds (as applicable). It is null/missing for all other provider types.

The first two digits indicate the state where the provider is located, using the SSA state codes; 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: PRVDR_BASE_FAC_CCN_NUM

LONG NAME: PRVDR_BASE_FAC_CCN_NUM

TYPE: CHAR

LENGTH: 6

SOURCE: NCH (base)

VALUES: —

COMMENT: This field was new in 2021. Prior to 2021, the CCN was populated in the PRVDR_NUM field. For 2021+ a subset of provider types also has a populated value for PRVDR_BASE_FAC_CCN_NUM.

This field is populated from the provider number (the CCN), from the first claim record included in the stay, modified as follows.

If position 3 of the provider number is one of the alpha characters on the list below, and position 4 is numeric, then populate position 3 of this field with the following numeric values:

Psych/Rehab Unit or Swing Bed Unit in a CAH:

If “M”, “R” or “Z”, populate “1”

Psych/Rehab Unit or Swing Bed in a IPPS Hospital:

If “S”, “T” or “U”, populate “0”

Swing Bed in LTCH:

If “W”, populate “2”

Swing Bed in a Rehab Facility:

If “Y”, populate “3”

If positions 3 and 4 of the provider number are both alpha characters, shown on the list below, then populate positions 3 and 4 of this field with the following numeric values:

Rehab/Psych Unit of LTCH:

If “TA” or “SA”, populate “20”

If “TB” or “SB”, populate “21”

If “TC” or “SC”, populate “22”

Psych Unit of Rehab Facility:

If “SD”, populate, “30”

Rehab/Psych Unit of Hospital:

If “TE” or “SE”, populate “33”

Rehab Unit of Psych Facility:

If “TF” populate, “40”

If “TG” populate, “41”

If “TH” populate, “42”

If “TJ” populate, “43”

If “TK” populate, “44”

For all else blank will be mapped in positions 1–6 of this field.

^ Back to TOC ^

PRVDR_FULL_CCN_NUM

LABEL: Provider Full CMS Certification Number (CCN)

DESCRIPTION: This variable is the extended CMS Certification Number (CCN).

This extended field is designed to allow for the identification of multiple campus hospitals. For multi-campus hospitals, all campuses contain the same first 6-digit CCN (reference PRVDR_BASE_FAC_NUM variable in this data file), but positions 7–13 may be used to distinguish between campuses (ex. 01, 02, 001, 002, A, etc.) In the future positions 7–13 may have other uses.

SHORT NAME: PRVDR_FULL_CCN_NUM

LONG NAME: PRVDR_FULL_CCN_NUM

TYPE: CHAR

LENGTH: 13

SOURCE: NCH (derived)

VALUES: —

COMMENT: This field is the full provider CMS certification number from the first claim record included in the stay.

This field was new in 2021.

^ Back to TOC ^

PRVDR_NUM_SPCL_UNIT_CD

LABEL: Provider Number Special Unit Code

DESCRIPTION: The code identifying the special numbering system for units of hospitals that are excluded from the prospective payment system (PPS) or hospitals with skilled nursing facility (SNF) swing-bed designation.

SHORT NAME: SPCLUNIT

LONG NAME: PRVDR_NUM_SPCL_UNIT_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: M = PPS-exempt psychiatric unit in a critical access hospital (CAH)
R = PPS-exempt rehabilitation unit in CAH
S = PPS-exempt psychiatric unit
T = PPS-exempt rehabilitation unit
U = Swing-bed short-term/acute care hospital
W = Swing-bed long-term hospital
Y = Swing-bed rehabilitation hospital
Z = Swing-bed rural primary care hospital (eff. 10/97 changed to critical access hospitals)
null/missing = facility is subject to PPS or SNF swing bed designation

COMMENT: If the third position of the provider number from the first claim record included in the stay equals 'M','R','S', 'T', 'U', 'W', 'Y' OR 'Z', it is moved to this field (and removed from the PRVDR_NUM), otherwise it is blank. Starting in 2021, these special codes remain part of the PRVDR_NUM and they are also populated in this field.

^ Back to TOC ^

PRVT_ROOM_CHRG_AMT

LABEL: Private Room Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for private room accommodations related to a beneficiary's stay.

SHORT NAME: PRVTAMT

LONG NAME: PRVT_ROOM_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 011x and 014x from all claim records included in the stay.

Exception for SNF RUGs demonstration effective 3/96 SNF update: field is derived from revenue center codes in the 9033–9044 series.

^ Back to TOC ^

PRVT_ROOM_DAY_CNT

LABEL: Private Room Day Count

DESCRIPTION: The count of the number of private room days used by the beneficiary for the stay.

SHORT NAME: PRVTDAY

LONG NAME: PRVT_ROOM_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 011x and 014x from all claim records included in the stay.

Exception for SNF RUGs demonstration effective 3/96 SNF update: field is derived from revenue center codes in the 9033–9044 series.

^ Back to TOC ^

PTNT_ADD_ON_PYMT_AMT

LABEL: Patient Add-On Payment Amount (new patient)

DESCRIPTION: This field represents a base rate increase factor for 1.3516 for new patient initial preventive physical examination (IPPE) and annual wellness visit.

SHORT NAME: PTNT_ADD_ON_PYMT_AMT

LONG NAME: PTNT_ADD_ON_PYMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the revenue center amount field (REV_CNTR_PTNT_ADD_ON_PMT_AMT) that is on any of the claim records included in the stay (i.e., sum of the REV_CNTR_PTNT_ADD_ON_PMT_AMT reported on the claims that comprise the stay).

This field is new in October 2014.

^ Back to TOC ^

RC_ALLOGENEIC_STEM_CELL_AMT

LABEL: Revenue Center Allogeneic Stem Cell Acquisition/Donor Services Amount)

DESCRIPTION: This field is used to identify revenue center allogeneic stem cell acquisition/donor services.

SHORT NAME: RC_ALLOGENEIC_STEM_CELL_AMT

LONG NAME: RC_ALLOGENEIC_STEM_CELL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV_CNTR_TOT_CHRG_AMT) associated with revenue center code (REV_CNTR_CD) '0815' from all claim records included in the stay.

This field is first available in 2016.

^ Back to TOC ^

RC_MODEL_REIMBRSMT_AMT

LABEL: Revenue Center Model Reimbursement Amount

DESCRIPTION: This this line-level field will be 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_MODEL_REIMBRSMT_AMT

LONG NAME: RC_MODEL_REIMBRSMT_AMT

TYPE: NUM

LENGTH: 10

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the Revenue Center Model Reimbursement Amount (REV-CNTR-MODEL-AMT) that is present on any line item on all claim records included in the stay (i.e., sum of the REV-CNTR-MODEL-AMT reported on the claims that comprised the stay).

For the participating hospitals in the PA model all inpatient and outpatient services (Facility/Technical Services) are considered part of the Model/Global Budget Services. Basically, all the services for a participating hospital would be global except for CAH Method II (85X) claim lines with revenue center codes 096X, 097X, and 098X. The CAH Method II professional services (rev codes 096X, 097X, and 098X) process as they do today, they have nothing to do with the model.

This field is first available in 2019.

^ Back to TOC ^

RC_NDC_1_CD

RC_NDC_2_CD

RC_NDC_3_CD

RC_NDC_4_CD

RC_NDC_5_CD

RC_NDC_6_CD

RC_NDC_7_CD

RC_NDC_8_CD

RC_NDC_9_CD

RC_NDC_10_CD

LABEL: Revenue Center National Drug Code (NDC) 1–10

DESCRIPTION: NDC numbers that are present in the revenue center trailers present on the claims that make up the stay.

SHORT NAME:

RC_NDC_1_CD
RC_NDC_2_CD
RC_NDC_3_CD
RC_NDC_4_CD
RC_NDC_5_CD
RC_NDC_6_CD
RC_NDC_7_CD
RC_NDC_8_CD
RC_NDC_9_CD
RC_NDC_10_CD

LONG NAME:

RC_NDC_1_CD
RC_NDC_2_CD
RC_NDC_3_CD
RC_NDC_4_CD
RC_NDC_5_CD
RC_NDC_6_CD
RC_NDC_7_CD
RC_NDC_8_CD
RC_NDC_9_CD
RC_NDC_10_CD

TYPE: CHAR

LENGTH: 11

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field comes from the REV-CNTR-IDE-NDC-UPC-NUM field. The first 10 NDC numbers that are present in the revenue center trailers present on the claims that make up the stay will be included in RC_NDC_1_CD through RC_NDC_10_CD.

^ Back to TOC ^

RC_RP_IND_CD

LABEL: Revenue Center Representative Payee (RP) Indicator Code

DESCRIPTION: This field at the line level to designate bypassing of the prior authorization processing for claims with a representative payee when an 'R' is present in the field.

SHORT NAME: RC_RP_IND_CD

LONG NAME: RC_RP_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: R = bypass representative payee

COMMENT: This field comes from the REV-RP-IND-CD that is present on the first claim record RP-IND-CD on the first claim then take the first found code (R) on any of the other claims that make up the stay.

Note that there is also a Claim Representative Payee (RP) Indicator Code (SAS variable called CLM_RP_IND_CD).

This field is first available in 2015.

^ Back to TOC ^

RDLGY_CHRG_AMT

LABEL: Radiology charge amount (excluding MRI) ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for radiology costs (including oncology, excluding MRI) related to a beneficiary's stay.

SHORT NAME: RDLGYAMT

LONG NAME: RDLGY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 028x, 032x, 033x, 034x, 035x and 040x from all claim records included in the stay.

Note that detailed revenue center charge amounts for radiology are available 2011 forward — reference fields: RDLGY_ONCOLOGY_AMT, RDLGY_DGNSTC_AMT, RDLGY_THRPTC_AMT, RDLGY_NUCLR_MDCN_AMT, RDLGY_CT_SCAN_AMT, RDLGY_OTHR_IMGNG_AMT.

Magnetic resonance imaging (MRI) charges appear in a separate field (called MRI_AMT).

^ Back to TOC ^

RDLGY_CT_SCAN_AMT

LABEL: Radiology CT Scan Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the Computed Tomographic (CT) services related to the beneficiary's stay.

SHORT NAME: RDLGY_CT_SCAN_AMT

LONG NAME: RDLGY_CT_SCAN_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0350', '0351', '0352', '0353', '0354', '0355', '0356', '0357', '0358' and '0359' from all claim records included in the stay. This field was new in 2011.

This field is one of six detailed radiology revenue center amounts (RDLGY_ONCOLOGY_AMT, RDLGY_DGNSTC_AMT, RDLGY_THRPTC_AMT, RDLGY_NUCLR_MDCN_AMT, RDLGY_CT_SCAN_AMT, RDLGY_OTHR_IMGNG_AMT).

Note that the sum of all the radiology charge amounts is available all years (field called RDLGYAMT).

^ Back to TOC ^

RDLGY_CT_SCAN_IND_SW

LABEL: Radiology Computed Tomographic (CT) Scan Indicator

DESCRIPTION: The switch indicating whether the beneficiary received radiology computed tomographic (CT) scan services during the stay.

SHORT NAME: CTSCANSW

LONG NAME: RDLGY_CT_SCAN_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 =No radiology CT scan (revenue code not 035X)
1 = Yes radiology CT scan (revenue code 035X)

COMMENT: This field is derived by checking for revenue center code 035X on any of the claim records included in the stay.

^ Back to TOC ^

RDLGY_DGNSTC_AMT

LABEL: Radiology Diagnostic Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the radiology diagnostic services related to the beneficiary's stay.

SHORT NAME: RDLGY_DGNSTC_AMT

LONG NAME: RDLGY_DGNSTC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0320', '0321', '0322', '0323', '0324', '0325', '0326', '0327', '0328' and '0329' from all claim records included in the stay.

This field was new in 2011.

This field is one of six detailed radiology revenue center amounts (RDLGY_ONCOLOGY_AMT, RDLGY_DGNSTC_AMT, RDLGY_THRPTC_AMT, RDLGY_NUCLR_MDCN_AMT, RDLGY_CT_SCAN_AMT, RDLGY_OTHR_IMGNG_AMT).

Note that the sum of all the radiology charge amounts is available all years (field called RDLGYAMT).

^ Back to TOC ^

RDLGY_DGNSTC_IND_SW

LABEL: Diagnostic Radiology Indicator

DESCRIPTION: The switch indicating whether the beneficiary received diagnostic radiology services during the stay.

SHORT NAME: DGNSTCSW

LONG NAME: RDLGY_DGNSTC_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = No diagnostic radiology (revenue code not 032x)
1 = Yes diagnostic radiology (revenue code 032x)

COMMENT: This field is derived by checking for revenue center code 032X on any of the claim records included in the stay.

^ Back to TOC ^

RDLGY_NUCLR_MDCN_AMT

LABEL: Radiology Nuclear Medicine Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the nuclear medicine services related to the beneficiary's stay.

SHORT NAME: RDLGY_NUCLR_MDCN_AMT

LONG NAME: RDLGY_NUCLR_MDCN_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0340', '0341', '0342', '0343', '0344', '0345', '0346', '0347', '0348' and '0349' from all claim records included in the stay. This field was new in 2011.

This field is one of six detailed radiology revenue center amounts (RDLGY_ONCOLOGY_AMT, RDLGY_DGNSTC_AMT, RDLGY_THRPTC_AMT, RDLGY_NUCLR_MDCN_AMT, RDLGY_CT_SCAN_AMT, RDLGY_OTHR_IMGNG_AMT).

Note that the sum of all the radiology charge amounts is available all years (field called RDLGYAMT).

^ Back to TOC ^

RDLGY_NUCLR_MDCN_IND_SW

LABEL: Radiology Nuclear Medicine Indicator

DESCRIPTION: The switch indicating whether the beneficiary received radiology nuclear medicine services during the stay.

SHORT NAME: NUCLR_SW

LONG NAME: RDLGY_NUCLR_MDCN_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = No nuclear medicine (revenue code not 034x)
1 = Yes nuclear medicine (revenue code 034x)

COMMENT: This field is derived by checking for revenue center code 034X on any of the claim records included in the stay.

^ Back to TOC ^

RDLGY_ONCLGY_IND_SW

LABEL: Oncology Indicator

DESCRIPTION: The switch indicating whether the beneficiary received oncology services during the stay.

SHORT NAME: ONCLGYSW

LONG NAME: RDLGY_ONCLGY_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = No oncology (revenue code not 028x)
1 = Yes oncology (revenue code 028x)

COMMENT: This field is derived by checking for revenue center code 028X on any of the claim records included in the stay.

^ Back to TOC ^

RDLGY_ONCOLOGY_AMT

LABEL: Oncology Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the oncology services related to the beneficiary's stay.

SHORT NAME: RDLGY_ONCOLOGY_AMT

LONG NAME: RDLGY_ONCOLOGY_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0280', '0281', '0282', '0283', '0284', '0285', '0286', '0287', '0288' and '0289' from all claim records included in the stay. This field was new in 2011.

This field is one of six detailed radiology revenue center amounts (RDLGY_ONCOLOGY_AMT, RDLGY_DGNSTC_AMT, RDLGY_THRPTC_AMT, RDLGY_NUCLR_MDCN_AMT, RDLGY_CT_SCAN_AMT, RDLGY_OTHR_IMGNG_AMT).

Note that the sum of all the radiology charge amounts is available all years (field called RDLGYAMT).

^ Back to TOC ^

RDLGY_OTHR_IMGNG_AMT

LABEL: Radiology Other Imaging Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the radiology other imaging services related to the beneficiary's stay.

SHORT NAME: RDLGY_OTHR_IMGNG_AMT

LONG NAME: RDLGY_OTHR_IMGNG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0400', '0401', '0402', '0403', '0404', '0405', '0406', '0407', '0408' and '0409' from all claim records included in the stay. This field was new in 2011.

This field is one of six detailed radiology revenue center amounts (RDLGY_ONCOLOGY_AMT, RDLGY_DGNSTC_AMT, RDLGY_THRPTC_AMT, RDLGY_NUCLR_MDCN_AMT, RDLGY_CT_SCAN_AMT, RDLGY_OTHR_IMGNG_AMT).

Note that the sum of all the radiology charge amounts is available all years (field called RDLGYAMT).

^ Back to TOC ^

RDLGY_OTHR_IMGNG_IND_SW

LABEL: Radiology Other Imaging Indicator

DESCRIPTION: The switch indicating whether the beneficiary received other radiology imaging services (e.g., ultrasound, mammography) during the stay.

SHORT NAME: IMGNG_SW

LONG NAME: RDLGY_OTHR_IMGNG_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = No other imaging services (revenue code not 040x)
1 = Yes other imaging services (revenue code 040x)

COMMENT: This field is derived by checking for revenue center code 040X on any of the claim records included in the stay.

^ Back to TOC ^

RDLGY_THRPTC_AMT

LABEL: Radiology Therapeutic Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the radiology therapeutic services related to the beneficiary's stay.

SHORT NAME: RDLGY_THRPTC_AMT

LONG NAME: RDLGY_THRPTC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV CNTR CD) '0330', '0331', '0332', '0333', '0334', '0335', '0336', '0337', '0338' and '0339' from all claim records included in the stay. This field was new in 2011.

This field is one of six detailed radiology revenue center amounts (RDLGY_ONCOLOGY_AMT, RDLGY_DGNSTC_AMT, RDLGY_THRPTC_AMT, RDLGY_NUCLR_MDCN_AMT, RDLGY_CT_SCAN_AMT, RDLGY_OTHR_IMGNG_AMT).

Note that the sum of all the radiology charge amounts is available all years (field called RDLGYAMT).

^ Back to TOC ^

RDLGY_THRPTC_IND_SW

LABEL: Therapeutic Radiology Indicator

DESCRIPTION: The switch indicating whether the beneficiary received therapeutic radiology services during the stay.

SHORT NAME: THRPTCSW

LONG NAME: RDLGY_THRPTC_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = No therapeutic radiology (revenue code not 033X)
1 = Yes therapeutic radiology (revenue code 033X)

COMMENT: This field is derived by checking for revenue center code 033X on any of the claim records included in the stay.

^ Back to TOC ^

SEMIPRVT_ROOM_CHRG_AMT

LABEL: Semi-Private Room Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for semi-private room accommodations related to a beneficiary's stay.

SHORT NAME: SPRVTAMT

LONG NAME: SEMIPRVT_ROOM_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 010x, 012x, 013x, and 016x–019x from all claim records included in the stay. Revenue center code 0161 (hospital at home, room, and board), effective for claims received on or after July 1, 2022, is excluded.

Exception for SNF RUGs demonstration eff. 3/96 SNF update: field is derived from revenue center codes in the 9019–9032 series.

^ Back to TOC ^

SEMIPRVT_ROOM_DAY_CNT

LABEL: Semi-Private Room Day Count

DESCRIPTION: The count of the number of semi-private room days used by the beneficiary for the stay.

SHORT NAME: SPRVTDAY

LONG NAME: SEMIPRVT_ROOM_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 010X, 012X, 013X, 016X–019X from all claim records included in the stay. Revenue center code 0161 (hospital at home, room, and board), effective for claims received on or after July 1, 2022, is excluded.

Exception for SNF RUGs demonstration eff. 3/96 SNF update: field is derived from revenue center codes in the 9019–9032 series.

^ Back to TOC ^

SLCT_RSN_CD

LABEL: Specifies whether this record is a case or control record

DESCRIPTION: Specifies whether this record is a case or control record.

SHORT NAME: SLCT_RSN_CD

LONG NAME: SLCT_RSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: —

COMMENT: This field is not populated.

^ Back to TOC ^

SNF_QUALN_FROM_DT

LABEL: Beginning date of beneficiary’s qualifying SNF stay

DESCRIPTION: The beginning date of the beneficiary's qualifying stay.

For Inpatient claims, the date relates to the prospective payment system (PPS) portion of the inlier for which there is no utilization to benefits. For skilled nursing facility (SNF) claims, the date relates to the qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than an 'A'.

SHORT NAME: QLFYFROM

LONG NAME: SNF_QUALN_FROM_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field comes from occurrence span code = 70 and related occurrence span from date, if present on any of the claim records included in the stay. If more than one record has an occurrence span code = 70, with different span dates, the date from the last claim record included in the stay is used.

^ Back to TOC ^

SNF_QUALN_THRU_DT

LABEL: Ending date of beneficiary’s qualifying SNF stay

DESCRIPTION: The ending date of the beneficiary's qualifying stay.

For Inpatient claims, the date relates to the prospective payment system (PPS) portion of the inlier for which there is no utilization to benefits. For skilled nursing facility (SNF) claims, the date relates to the qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than an 'A'.

SHORT NAME: QLFYTHRU

LONG NAME: SNF_QUALN_THRU_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field comes from occurrence span code = 70 and related occurrence span from date, if present on any of the claim records included in the stay. If more than one record has an occurrence span code = 70, with different span dates, the date from the last claim record included in the stay is used.

^ Back to TOC ^

SPCH_PTHLGY_CHRG_AMT

LABEL: Speech Pathology Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for speech pathology services (speech, language, audiology) provided during the beneficiary's stay.

SHORT NAME: SPCH_AMT

LONG NAME: SPCH_PTHLGY_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 044x and 047x from all claim records included in the stay.

^ Back to TOC ^

SQSTRTN_RDCTN_AMT

LABEL: Sequestration Reduction Amount

DESCRIPTION: This field represents the sequestration reduction amount (rounded to whole dollars).

SHORT NAME: SQSTRTN_RDCTN_AMT

LONG NAME: SQSTRTN_RDCTN_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the amount field (CLM-VAL-AMT) found in the value code trailer for value code (CLM-VAL-CD) equal to '73' for any claim records included in the stay.

Starting on April 1, 2013, the Budget Control Act of 2011 reduced Medicare payments to all providers by 2 percent through a mechanism known as sequestration. This reduction applies only to the Medicare payment amount and does not affect beneficiaries' liability for deductibles or coinsurance. The effects of this reduction are reflected in the Medicare claim payment amount (variable called PMT_AMT).

This field is new in 2013.

^ Back to TOC ^

SRC_IP_ADMSN_CD

LABEL: Source of admission to an Inpatient facility — for newborn admit is type of delivery code

DESCRIPTION: The code indicating the source of the beneficiary's admission to an Inpatient facility or, for newborn admission, the type of delivery.

SHORT NAME: SRC_ADMS

LONG NAME: SRC_IP_ADMSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES:
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 — The means by which the patient was admitted is not known.
A = Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital — patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
B = Transfer from Another Home Health Agency — The patient was admitted to this home health agency as a transfer from another home health agency. (Discontinued July 1, 2010 — 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 (Effective 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: This field comes from the source Inpatient admission code that is present on the last claim record included in the stay.

^ Back to TOC ^

SRGCL_PRCDR_1_CD

SRGCL_PRCDR_2_CD

SRGCL_PRCDR_3_CD

SRGCL_PRCDR_4_CD

SRGCL_PRCDR_5_CD

SRGCL_PRCDR_6_CD

SRGCL_PRCDR_7_CD

SRGCL_PRCDR_8_CD

SRGCL_PRCDR_9_CD

SRGCL_PRCDR_10_CD

SRGCL_PRCDR_11_CD

SRGCL_PRCDR_12_CD

SRGCL_PRCDR_13_CD

SRGCL_PRCDR_14_CD

SRGCL_PRCDR_15_CD

SRGCL_PRCDR_16_CD

SRGCL_PRCDR_17_CD

SRGCL_PRCDR_18_CD

SRGCL_PRCDR_19_CD

SRGCL_PRCDR_20_CD

SRGCL_PRCDR_21_CD

SRGCL_PRCDR_22_CD

SRGCL_PRCDR_23_CD

SRGCL_PRCDR_24_CD

SRGCL_PRCDR_25_CD

LABEL: Principal Procedure code

DESCRIPTION: The ICD-9-CM or ICD-10-PCS code identifying the principal surgical procedure performed during the beneficiary's stay (variable called PRCDRCD1).

SHORT NAME:

PRCDRCD1
PRCDRCD2
PRCDRCD3
PRCDRCD4
PRCDRCD5
PRCDRCD6
PRCDRCD7
PRCDRCD8
PRCDRCD9
PRCDRCD10
PRCDRCD11
PRCDRCD12
PRCDRCD13
PRCDRCD14
PRCDRCD15
PRCDRCD16
PRCDRCD17
PRCDRCD18
PRCDRCD19
PRCDRCD20
PRCDRCD21
PRCDRCD22
PRCDRCD23
PRCDRCD24
PRCDRCD25

LONG NAME:

SRGCL_PRCDR_1_CD
SRGCL_PRCDR_2_CD
SRGCL_PRCDR_3_CD
SRGCL_PRCDR_4_CD
SRGCL_PRCDR_5_CD
SRGCL_PRCDR_6_CD
SRGCL_PRCDR_7_CD
SRGCL_PRCDR_8_CD
SRGCL_PRCDR_9_CD
SRGCL_PRCDR_10_CD
SRGCL_PRCDR_11_CD
SRGCL_PRCDR_12_CD
SRGCL_PRCDR_13_CD
SRGCL_PRCDR_14_CD
SRGCL_PRCDR_15_CD
SRGCL_PRCDR_16_CD
SRGCL_PRCDR_17_CD
SRGCL_PRCDR_18_CD
SRGCL_PRCDR_19_CD
SRGCL_PRCDR_20_CD
SRGCL_PRCDR_21_CD
SRGCL_PRCDR_22_CD
SRGCL_PRCDR_23_CD
SRGCL_PRCDR_24_CD
SRGCL_PRCDR_25_CD

TYPE: CHAR

LENGTH: 7

SOURCE: NCH

VALUES: —

COMMENT: ICD-10 procedure codes were used starting October 2015.

The surgical procedure version code (variables SRGCL_PRCDR_VRSN_CD_1–SRGCL_PRCDR_VRSN_CD_25) indicates whether this code is ICD-9 or ICD-10.

PRCDRCD7–PRCDRCD25 were new in 2009 (earlier surgical procedure codes were available all years; we had 1–6 historically).

The principal procedure code is stored as the first procedure code (PRCDRCD1). ^ Back to TOC ^

SRGCL_PRCDR_CD_CNT

LABEL: Surgical procedure codes included in stay

DESCRIPTION: The count of the number of surgical procedure codes included in the stay.

SHORT NAME: PRCDRCNT

LONG NAME: SRGCL_PRCDR_CD_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: XXX

COMMENT: This field is derived by counting the procedure codes that are reported on the last claim record included in the stay.

^ Back to TOC ^

SRGCL_PRCDR_DT_CNT

LABEL: Dates associated with surgical procedures included in stay

DESCRIPTION: The count of the number of dates associated with the surgical procedures included in the stay.

SHORT NAME: PRCDTCNT

LONG NAME: SRGCL_PRCDR_DT_CNT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: 0–25

COMMENT: This field is derived by counting the surgical procedures dates that are reported on the last claim record included in the stay.

Note that until 2009, only six procedure codes were allowed.

^ Back to TOC ^

SRGCL_PRCDR_IND_SW

LABEL: Surgical Procedure Indicator

DESCRIPTION: The switch indicating whether there were any surgical procedures performed during the beneficiary's stay.

SHORT NAME: PRCDRSW

LONG NAME: SRGCL_PRCDR_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: 0 = No surgery indicated
1 = Yes surgery indicated

COMMENT: This field is derived by checking for the presence of procedure codes on the last claim record included in the stay.

^ Back to TOC ^

SRGCL_PRCDR_PRFRM_1_DT

SRGCL_PRCDR_PRFRM_2_DT

SRGCL_PRCDR_PRFRM_3_DT

SRGCL_PRCDR_PRFRM_4_DT

SRGCL_PRCDR_PRFRM_5_DT

SRGCL_PRCDR_PRFRM_6_DT

SRGCL_PRCDR_PRFRM_7_DT

SRGCL_PRCDR_PRFRM_8_DT

SRGCL_PRCDR_PRFRM_9_DT

SRGCL_PRCDR_PRFRM_10_DT

SRGCL_PRCDR_PRFRM_11_DT

SRGCL_PRCDR_PRFRM_12_DT

SRGCL_PRCDR_PRFRM_13_DT

SRGCL_PRCDR_PRFRM_14_DT

SRGCL_PRCDR_PRFRM_15_DT

SRGCL_PRCDR_PRFRM_16_DT

SRGCL_PRCDR_PRFRM_17_DT

SRGCL_PRCDR_PRFRM_18_DT

SRGCL_PRCDR_PRFRM_19_DT

SRGCL_PRCDR_PRFRM_20_DT

SRGCL_PRCDR_PRFRM_21_DT

SRGCL_PRCDR_PRFRM_22_DT

SRGCL_PRCDR_PRFRM_23_DT

SRGCL_PRCDR_PRFRM_24_DT

SRGCL_PRCDR_PRFRM_25_DT

LABEL: Principal Procedure Date

DESCRIPTION: The date on which the surgical procedure was performed during the beneficiary's stay. This element corresponds with the surgical procedure code (variables called PRCDRCD1–PRCDRCD25).

SHORT NAME:

PRCDRDT1
PRCDRDT2
PRCDRDT3
PRCDRDT4
PRCDRDT5
PRCDRDT6
PRCDRDT7
PRCDRDT8
PRCDRDT9
PRCDRDT10
PRCDRDT11
PRCDRDT12
PRCDRDT13
PRCDRDT14
PRCDRDT15
PRCDRDT16
PRCDRDT17
PRCDRDT18
PRCDRDT19
PRCDRDT20
PRCDRDT21
PRCDRDT22
PRCDRDT23
PRCDRDT24
PRCDRDT25

LONG NAME:

SRGCL_PRCDR_PRFRM_1_DT
SRGCL_PRCDR_PRFRM_2_DT
SRGCL_PRCDR_PRFRM_3_DT
SRGCL_PRCDR_PRFRM_4_DT
SRGCL_PRCDR_PRFRM_5_DT
SRGCL_PRCDR_PRFRM_6_DT
SRGCL_PRCDR_PRFRM_7_DT
SRGCL_PRCDR_PRFRM_8_DT
SRGCL_PRCDR_PRFRM_9_DT
SRGCL_PRCDR_PRFRM_10_DT
SRGCL_PRCDR_PRFRM_11_DT
SRGCL_PRCDR_PRFRM_12_DT
SRGCL_PRCDR_PRFRM_13_DT
SRGCL_PRCDR_PRFRM_14_DT
SRGCL_PRCDR_PRFRM_15_DT
SRGCL_PRCDR_PRFRM_16_DT
SRGCL_PRCDR_PRFRM_17_DT
SRGCL_PRCDR_PRFRM_18_DT
SRGCL_PRCDR_PRFRM_19_DT
SRGCL_PRCDR_PRFRM_20_DT
SRGCL_PRCDR_PRFRM_21_DT
SRGCL_PRCDR_PRFRM_22_DT
SRGCL_PRCDR_PRFRM_23_DT
SRGCL_PRCDR_PRFRM_24_DT
SRGCL_PRCDR_PRFRM_25_DT

TYPE: DATE

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: This field is the actual date associated with the principal or one of up to 24 other surgical procedure codes that is present on the last claim record included in the stay.

There may be up to 25 procedures and dates.

Note that until 2009, only six procedure codes were allowed. The principal procedure code is stored as the first procedure code (PRCDRCD1).

^ Back to TOC ^

SRGCL_PRCDR_VRSN_CD

LABEL: Surgical Procedure Version Code (Earlier Version)

DESCRIPTION: The code is used to indicate if the surgical procedure code is ICD-9 or ICD-10.

SHORT NAME: SRGCL_PRCDR_VRSN_CD

LONG NAME: SRGCL_PRCDR_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null/missing = ICD-9-CM
9 = ICD-9-CM
0 = ICD-10-PCS

COMMENT: ICD-10 procedure codes were used starting October 2015.

This field was populated only in 2009 and 2010.

^ Back to TOC ^

SRGCL_PRCDR_VRSN_CD_1

SRGCL_PRCDR_VRSN_CD_2

SRGCL_PRCDR_VRSN_CD_3

SRGCL_PRCDR_VRSN_CD_4

SRGCL_PRCDR_VRSN_CD_5

SRGCL_PRCDR_VRSN_CD_6

SRGCL_PRCDR_VRSN_CD_7

SRGCL_PRCDR_VRSN_CD_8

SRGCL_PRCDR_VRSN_CD_9

SRGCL_PRCDR_VRSN_CD_10

SRGCL_PRCDR_VRSN_CD_11

SRGCL_PRCDR_VRSN_CD_12

SRGCL_PRCDR_VRSN_CD_13

SRGCL_PRCDR_VRSN_CD_14

SRGCL_PRCDR_VRSN_CD_15

SRGCL_PRCDR_VRSN_CD_16

SRGCL_PRCDR_VRSN_CD_17

SRGCL_PRCDR_VRSN_CD_18

SRGCL_PRCDR_VRSN_CD_19

SRGCL_PRCDR_VRSN_CD_20

SRGCL_PRCDR_VRSN_CD_21

SRGCL_PRCDR_VRSN_CD_22

SRGCL_PRCDR_VRSN_CD_23

SRGCL_PRCDR_VRSN_CD_24

SRGCL_PRCDR_VRSN_CD_25

LABEL: MEDPAR Surgical Procedure Version Code 1 (ICD-9-CM or ICD-10-PCS)

DESCRIPTION: The code is used to indicate if the surgical procedure code (variables called PRCDRCD1 -PRCDRCD25) is ICD-9-CM or ICD-10-PCS.

SHORT NAME:

SRGCL_PRCDR_VRSN_CD_1
SRGCL_PRCDR_VRSN_CD_2
SRGCL_PRCDR_VRSN_CD_3
SRGCL_PRCDR_VRSN_CD_4
SRGCL_PRCDR_VRSN_CD_5
SRGCL_PRCDR_VRSN_CD_6
SRGCL_PRCDR_VRSN_CD_7
SRGCL_PRCDR_VRSN_CD_8
SRGCL_PRCDR_VRSN_CD_9
SRGCL_PRCDR_VRSN_CD_10
SRGCL_PRCDR_VRSN_CD_11
SRGCL_PRCDR_VRSN_CD_12
SRGCL_PRCDR_VRSN_CD_13
SRGCL_PRCDR_VRSN_CD_14
SRGCL_PRCDR_VRSN_CD_15
SRGCL_PRCDR_VRSN_CD_16
SRGCL_PRCDR_VRSN_CD_17
SRGCL_PRCDR_VRSN_CD_18
SRGCL_PRCDR_VRSN_CD_19
SRGCL_PRCDR_VRSN_CD_20
SRGCL_PRCDR_VRSN_CD_21
SRGCL_PRCDR_VRSN_CD_22
SRGCL_PRCDR_VRSN_CD_23
SRGCL_PRCDR_VRSN_CD_24
SRGCL_PRCDR_VRSN_CD_25

LONG NAME:

SRGCL_PRCDR_VRSN_CD_1
SRGCL_PRCDR_VRSN_CD_2
SRGCL_PRCDR_VRSN_CD_3
SRGCL_PRCDR_VRSN_CD_4
SRGCL_PRCDR_VRSN_CD_5
SRGCL_PRCDR_VRSN_CD_6
SRGCL_PRCDR_VRSN_CD_7
SRGCL_PRCDR_VRSN_CD_8
SRGCL_PRCDR_VRSN_CD_9
SRGCL_PRCDR_VRSN_CD_10
SRGCL_PRCDR_VRSN_CD_11
SRGCL_PRCDR_VRSN_CD_12
SRGCL_PRCDR_VRSN_CD_13
SRGCL_PRCDR_VRSN_CD_14
SRGCL_PRCDR_VRSN_CD_15
SRGCL_PRCDR_VRSN_CD_16
SRGCL_PRCDR_VRSN_CD_17
SRGCL_PRCDR_VRSN_CD_18
SRGCL_PRCDR_VRSN_CD_19
SRGCL_PRCDR_VRSN_CD_20
SRGCL_PRCDR_VRSN_CD_21
SRGCL_PRCDR_VRSN_CD_22
SRGCL_PRCDR_VRSN_CD_23
SRGCL_PRCDR_VRSN_CD_24
SRGCL_PRCDR_VRSN_CD_25

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Null/missing = ICD-9-CM
9 = ICD-9-CM
0 = CD-10-PCS

COMMENT: ICD-10 codes were used starting October 2015.

This field was new in 2011.

^ Back to TOC ^

SS_LS_SNF_IND_CD

LABEL: Short Stay/Long Stay/SNF Provider Indicator Code

DESCRIPTION: The code indicating whether the stay is a short stay, long stay, or skilled nursing facility (SNF).

SHORT NAME: SSLSSNF

LONG NAME: SS_LS_SNF_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: N = SNF Stay (3rd digit of Provider ID = 5, 6, U, W, Y, or Z)
S = Short-Stay (3rd digit of Provider ID = 0, M, R, S, T)
L = Long-Stay (All Others)

COMMENT: This field is derived from the third position of the provider number that is present on the first claim record included in the stay.

^ Back to TOC ^

STAY_2_IND_SW

LABEL: Two Midnight Stay Indicator

DESCRIPTION: MEDPAR 2 Day Midnight Stay Indicator Switch

SHORT NAME: STAY_2_IND_SW

LONG NAME: STAY_2_IND_SW

TYPE: CHAR

LENGTH: 1

SOURCE: NCH

VALUES: Y = Yes, the beneficiary received outpatient services within the hospital, prior to admission
N = No outpatient services immediately prior to admission

COMMENT: CMS monitors the frequency of beneficiaries being treated as hospital outpatients (e.g., being treated in observation units, which is paid under Medicare Part B). CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admission is reasonable and payable under Medicare Part A. In general, the Two-Midnight rule stated that Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.

This field comes from the Claim Occurrence Span Code = 72 that is present on any claim included in the stay. If an occurrence span code = 72 is found, set the indicator to 'Y'. If no occurrence span code of 72 is found on any of the claims set the indicator to 'N'.

^ Back to TOC ^

STAY_FINL_ACTN_CLM_CNT

LABEL: Number of claims (final action) included in stay

DESCRIPTION: The count of the number of claim records (final action) included in the stay.

SHORT NAME: FACLMCNT

LONG NAME: STAY_FINL_ACTN_CLM_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by counting the number of final action claims used to create the stay.

^ Back to TOC ^

TAKE_HOME_AMT

LABEL: Medical/Surgical Supplies Take Home Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for the medical/surgical take home supplies related to the beneficiary's stay.

SHORT NAME: TAKE_HOME_AMT

LONG NAME: TAKE_HOME_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0273' from all claim records included in the stay. This field was new in 2011.

This field is one of 15 detailed medical surgical amounts. Reference:

MDCL_SRGCL_GNRL_AMT, MDCL_SRGCL_NSTRL_AMT, MDCL_SRGCL_STRL_AMT, MDCL_SRGCL_DRSNG_AMT, MDCL_SRGCL_PCMKR_AMT, MDCL_SRGCL_MISC_AMT, TAKE_HOME_AMT, PRSTHTC_ORTHTC_AMT, INTRAOCULAR_LENS_AMT, OXYGN_TAKE_HOME_AMT, OTHR_IMPLANTS_AMT, OTHR_SUPLIES_DVC_AMT, INCDNT_RDLGY_AMT, INCDNT_DGNSTC_SRVCS_AMT, and INVSTGTNL_DVC_AMT

Note that the sum of all the medical/surgical supplies charge amounts is available all years (field called MDCL_SUPLY_CHRG_AMT).

^ Back to TOC ^

TOT_CHRG_AMT

LABEL: Total Charge Amount ($)

DESCRIPTION: The total amount (rounded to whole dollars) of all charges (covered and non-covered) for all services provided to the beneficiary for the stay.

SHORT NAME: TOTCHRG

LONG NAME: TOT_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the total charge amount from all claim records included in the stay (i.e., the sum of total charges reported on the claims that comprise the stay).

^ Back to TOC ^

TOT_COINSRNC_DAY_CNT

LABEL: MEDPAR Beneficiary Total Coinsurance Day Count

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

SHORT NAME: COIN_DAY

LONG NAME: TOT_COINSRNC_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: For Inpatient services, the beneficiary is liable for a daily coinsurance amount after the 60th day and before the 91st day in a single spell of illness; for SNF services, the beneficiary is liable for a daily coinsurance amount after the 20th day and before the 101st day in a single spell of illness.

This field is derived by accumulating the coinsurance day count that is present on any of the claim records included in the stay (i.e., the sum of coinsurance days reported on the claims that comprise the stay).

^ Back to TOC ^

TOT_CVR_CHRG_AMT

LABEL: Total Covered Charge Amount ($)

DESCRIPTION: The portion of the total charges amount (rounded to whole dollars) that is covered by Medicare for the stay.

SHORT NAME: CVRCHRG

LONG NAME: TOT_CVR_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by calculating the covered charges from all claim records included in the stay (i.e., subtracted the revenue center non-covered charge amount from the revenue center total charge amount for revenue center code = 0001 that is reported on the claims that comprise the stay; sum the results for all claims for the stay).

The exception to this formula is if there exists an erroneous condition relative to revenue center code 0001, the calculation will be made for each revenue enter code included on the claims that comprise the stay with the results summed to create the total.

^ Back to TOC ^

TOT_PPS_CPTL_AMT

LABEL: Total PPS Capital Amount ($)

DESCRIPTION: The total amount (rounded to whole dollars) that is payable for capital for the prospective payment system (PPS) (e.g., reimbursement for depreciation, rent, certain interest, real estate taxes for hospital buildings/equipment that are subject to PPS).

SHORT NAME: PPS_CPTL

LONG NAME: TOT_PPS_CPTL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the total PPS capital amounts that are present on any of the claim records included in the stay (i.e., the sum of total PPS capital amounts reported on the claims that comprise the stay).

This field is already included in the MEDPAR Medicare payment amount (field called PMT_AMT).

^ Back to TOC ^

TRNSPLNT_IND_CD

LABEL: Organ Transplant Indicator Code

DESCRIPTION: The code indicating whether the beneficiary received an organ transplant during the stay.

SHORT NAME: TRNSPLNT

LONG NAME: TRNSPLNT_IND_CD

TYPE: CHAR

LENGTH: 1

SOURCE: MedPAR (derived)

VALUES: 0 = No organ or kidney transplant (revenue code not 0362 or 0367)
2 = Organ transplant other than kidney (revenue code 0362)
7 = Kidney transplant (revenue code 0367)

COMMENT: This field is derived by checking for the presence of transplant revenue center code (0362 or 0367) on any of the claim records included in the stay.

^ Back to TOC ^

UNCOMPD_CARE_PYMT_AMT

LABEL: Uncompensated Care Payment Amount

DESCRIPTION: The field represents the uncompensated care amount (rounded to whole dollars) of the payment for disproportionate share hospitals (DSH) hospitals.

SHORT NAME: UNCOMPD_CARE_PYMT_AMT

LONG NAME: UNCOMPD_CARE_PYMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: Uncompensated care payments are effective for claims with discharge dates on or after 10/1/13 forward. For payment policies, reference the Affordable Care Act section 3133 and the FY2014 IPPS final rule.

This field is derived by accumulating the Claim inpatient prospective payment system (IPPS) Uncompensated Care Payment Amount (previously referred to as the Flex Payment 1 Amount field; CLM_ IPPS_FLEX_PMT_1_AMT) that is present on any of the claim records included in the stay.

This field is new in 2013.

^ Back to TOC ^

UNIQ_TRKNG_NUM

LABEL: Unique Tracking Number

DESCRIPTION: This field identifies the unique tracking number assigned to each prior authorization request.

SHORT NAME: UNIQ_TRKNG_NUM

LONG NAME: UNIQ_TRKNG_NUM

TYPE: CHAR

LENGTH: 14

SOURCE: NCH

VALUES: —

COMMENT: This field comes from the Unique Tracking Number (CLM-UNIQ-TRKNG-NUM) that is present on the first claim record included in the stay. If there is no unique tracking number on the 1st claim record, then take the first found code on any of the other claims that make up the stay.

This field is new in 2014 (not populated through 2018); it only applies to Inpatient/SNF claims.

Stays with a prior authorization requirement are identified by the prior authorization indicator code field (called PA_IND_CD).

^ Back to TOC ^

USED_DME_CHRG_AMT

LABEL: Used Durable Medical Equipment (DME) Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for used Durable Medical Equipment (DME; purchase of used DME) related to the beneficiary's stay.

SHORT NAME: UDME_AMT

LONG NAME: USED_DME_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 0293 from all claim records included in the stay.

Note that an additional field contains charge amounts for new DME and rentals (variable called DME_AMT).

^ Back to TOC ^

UTLZTN_DAY_CNT

LABEL: Covered days of care chargeable to Medicare utilization for stay

DESCRIPTION: The count of the number of covered days of care that are chargeable to Medicare utilization for the stay.

SHORT NAME: UTIL_DAY

LONG NAME: UTLZTN_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the utilization day count that is present on any of the claim records included in the stay (i.e., the sum of utilization days reported on the claims that comprise the stay).

^ Back to TOC ^

VAL_CD_Q1_PYMT_RDCTN_AMT

LABEL: Value Code Q1 Payment Reduction Amount

DESCRIPTION: This field is derived by accumulating the amount field (CLM VAL AMT) found in the value code trailer for value code (CLM VAL CD) equal to 'Q1' for any claim records included in the stay.

SHORT NAME: VAL_CD_Q1_PYMT_RDCTN_AMT

LONG NAME: VAL_CD_Q1_PYMT_RDCTN_AMT

TYPE: NUM

LENGTH: 10

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is new in 2018.

The Q1 in the Value Code is for an ACO Payment Reduction Amount (Pioneer Reduction).

^ Back to TOC ^

VAL_CD_QB_OCM_PYMT_ADJSTMT_AMT

LABEL: Value Code QB OCM + Payment Adjustment Amount

DESCRIPTION: This field contains the QB OCM + payment adjustment amount.

SHORT NAME: VAL_CD_QB_OCM_PYMT_ADJSTMT_AMT

LONG NAME: VAL_CD_QB_OCM_PYMT_ADJSTMT_AMT

TYPE: NUM

LENGTH: 10

SOURCE: NCH

VALUES: —

COMMENT: This field is derived by accumulating the amount field (CLM VAL AMT) found in the value code trailer for value code (CLM VAL CD) equal to 'QB' for any claim records included in the stay.

This field is new in 2019.

^ Back to TOC ^

VBP_ADJSTMT_AMT

LABEL: Hospital Value Based Purchasing (VBP) Amount

DESCRIPTION: This field represents the amount (rounded to whole dollars) of the Hospital Value Based Purchasing (VBP) Amount. This could be an additional payment on the claim or a reduction, depending on the hospital's score.

SHORT NAME: VBP_ADJSTMT_AMT

LONG NAME: VBP_ADJSTMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: —

COMMENT: For details on the VBP program reference the CMS Value-based purchasing webpage (e.g., http://www.cms.gov/Medicare/Quality-Initiatives-Patient-assessment-Instruments/hospital-value-based-purchasing/index.html?rediret=/hospital-value-based-purchasing

This field is derived by accumulating the Claim inpatient prospective payment system (IPPS) value-based purchasing adjustment amount (previously referred to as Flex Payment 3 Amount field; CLM_IPPS_FLEX_PMT_3_AMT) that is present on any of the claim records included in the stay.

This field is new in 2013.

^ Back to TOC ^

VBP_ADJSTMT_PCT

LABEL: Value Based Purchasing (VBP) Adjustment Percent

DESCRIPTION: Under the Hospital Value Based Purchasing (HVBP) program, the percent used to identify an adjustment made to certain subsection (d) IPPS hospitals base operating DRG amount, in accordance with their Total Performance Score (TPS) as required by the Affordable Care Act (ACA). This is the Value Based Purchasing Score.

SHORT NAME: VBP_ADJSTMT_PCT

LONG NAME: VBP_ADJSTMT_PCT

TYPE: NUM

LENGTH: 8

SOURCE: NCH

VALUES: X.XXXXXXXXXXX

COMMENT: This field comes from the Claim VBP Adjustment Percent (CLM-VBP-CLM-ADJSTMT-PCT) that is present on the last claim record included in the stay.

The Affordable Care Act (ACA; Section 3001) excludes from HVBP program hospitals that meet certain conditions. Refer to the VBP Participant Indicator Code (field called VBP_PRTCPNT_IND_CD).

^ Back to TOC ^

VBP_PRTCPNT_IND_CD

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

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

SHORT NAME: VBP_PRTCPNT_IND_CD

LONG NAME: 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 Affordable Care Act (ACA; Section 3001) excludes from HVBP program hospitals that meet certain conditions.

This field comes from the Claim VBP Participant

Indicator code (CLM-VBP-PRTCPNT-IND-CD) that is present on the first claim record included in the stay. If there is no Claim VBP Participant Indicator code on the first claim, then the first found code on any of the other claims that make up the stay is used.

This field is new in 2011.

^ Back to TOC ^

WARD_CHRG_AMT

LABEL: Ward Charge Amount ($)

DESCRIPTION: The charge amount (rounded to whole dollars) for ward accommodations related to a beneficiary's stay.

SHORT NAME: WARDAMT

LONG NAME: WARD_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center total charge amount associated with revenue center code 015x from all claim records included in the stay.

Exception for SNF RUGs demonstration eff. 3/96 SNF update: field is derived from revenue center codes in the 9000-9018 series.

^ Back to TOC ^

WARD_DAY_CNT

LABEL: Ward Day Count

DESCRIPTION: The count of the number of ward care days used by the beneficiary for the stay.

SHORT NAME: WARDDAY

LONG NAME: WARD_DAY_CNT

TYPE: NUM

LENGTH: 8

SOURCE: MedPAR (derived)

VALUES: —

COMMENT: This field is derived by accumulating the revenue center unit count associated with accommodation revenue center code 015x from all claim records included in the stay.

Exception for SNF RUGs demonstration eff. 3/96 SNF update: field is derived from revenue center codes in the 9000-9018 series.

^ Back to TOC ^

WRNG_IND_CD

LABEL: Warning indicators code specifying detailed billing info

DESCRIPTION: The codes (commonly called warning indicators) specify detailed billing information obtained from the claims analyzed for the stay. The purpose of these codes is to provide additional information for the MEDPAR user, i.e., let the user know whether the stay included adjustments, a single claim or multiple claims, any error conditions, etc.

SHORT NAME: WRNGCD

LONG NAME: WRNG_IND_CD

TYPE: CHAR

LENGTH: 18

SOURCE: NCH

VALUES: This is an 18-digit character string, where each digit of the warning indicator has a specific meaning.

For example, if the value=00010002000000000 (1 in the 4th digit and 2 in the 8th digit), then the beneficiary had a greater number of utilization days than the LOS day count and the beneficiary had a death date that was prior to the admission date on for the stay. If the value = 00000000100000000 (1 in the 9th digit), then the beneficiary had a claim pass thru per diem amount on the claim.

Warning indicator 1 ('adjustment indicator' derived from the presence of query code values noted below on any of the claim records included in the analysis):

0 = No adjustment (no query code = 0 or 5)
1 = Credit adjustment (query code = 0)
2 = Debit adjustment (query code = 5)
3 = Credit and debit adjustment (both query code = 0 and 5)

Warning indicator 2 ('error condition' derived from checking the edit code trailer on the final action claims(s) that comprise the stay):

0 = No error
1 = Error condition

Warning indicator 3 ('reimbursement/total charge indicator' derived after summing up fields on the final action claim(s) that comprise the stay; checks resulting Medicare payment amount (commonly called reimbursement), total charge amount, as well as beneficiary primary payer amount and utilization day count):

0 = Medicare payment amount and total charge amount > zeroes
1 = Medicare payment amount and total charge amount < zeroes
2 = Medicare payment amount is a credit
3 = Total charge amount is a credit
4 = Medicare payment amount, total charge amount, beneficiary primary payer claim payment amount, and utilization day count = zeroes

Warning indicator 4 ('utilization day/LOS day indicator' derived after summing up fields on the final action claim(s) that comprise the stay; compares resulting utilization day count and length-of-stay [LOS] count):

0 = Utilization day count = LOS day count
1 = Utilization day count < LOS day count
2 = Utilization day count > LOS day count

Warning indicator 5 ('single/multiple claim indicator' derived when the stay record is created by checking the number of final action claims that comprise the stay):

0 = Stay includes a single final action claim
1 = Stay includes multiple final action claims
2 = Stay includes multiple final action claims and beneficiary is still a patient (applicable to SNF stays only)

Warning indicator 6 ('intermediary cancel indicator' derived from the presence of the values noted below for intermediary claim action code and intermediary-requested claim cancel reason code on any of the claims included in the analysis.

If multiple claims contain these values, latest claim is used. If both specified action code and cancel reason code are present, cancel reason code takes priority.):

0 = No cancel action
1 = Cancel action by credit adjustment (action code = (2 or 6)
2 = Cancel action only (action code = 4)
3 = Coverage transfer (cancel reason code = C)
4 = Plan transfer (cancel reason code = P)
5 = Scramble (cancel reason code = S)
6 = Duplicate billing (cancel reason code = D)
7 = Other (cancel reason code = H)
8 = Combining 2 spells or 2 beneficiary records (cancel reason code = L)

Warning indicator 7 ('state/county numeric indicator' derived from checking the format of the beneficiary residence SSA state code and beneficiary residence county code on the final action claim(s) that comprise the stay; determine if in numeric range):

0 = State and county codes are valid numeric values
1 = State and county codes are not in numeric range
2 = State code is not in numeric range
3 = County code is not in numeric range

Warning indicator 8 ('duplicate indicator' derived from the presence of two claim records with the same claim number admission date, provider number, claim from/thru date, HCFA process date and query code; death/admission date indicator derived by comparing the admission date on the final claim(s) that comprise the stay to the beneficiary death date):

0 = Do duplicate record
1 = Duplicate record
2 = Death date < admission date
3 = Death date < admission date and duplicate record

Warning indicator 9 ('pass-thru indicator' derived from the presence of a pass thru per diem amount on the final action claim(s) that comprise the stay):

0 = No pass thru per diem present (non-PPS)
1 = Pass thru per diem present on final action claim

Warning indicator 10 (Resource Utilization Groups [RUGs] indicator applicable to 'NHCMQ RUGs III SNF demo' stay records derived from the presence of 9,000 series revenue center codes.)

0 = No RUGs 9,000 series revenue center codes
2 = RUGs 9,000 series revenue center code(s)
3 = RUGs 9,000 series revenue center code(s)
4 = RUGs 9,000 series revenue center code(s)

Warning indicators 11–17 (not yet assigned; zeroes will be present)

COMMENT: Each of the digits identify a specific item of interest to users of the MEDPAR file. Warning indicators 1 and 6, and the first two values of indicator 8, are set early in the process – while processing all claims through the final action algorithm, prior to the creation of the stay record. The other indicators are derived from the claims remaining after the final action processing, which are used to create the stay record.

^ Back to TOC ^