NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Inpatient Fee-For-Service Base Claims
Date Created: 29JAN2021
Number of Variables: 249

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
PATIENT_ID	NHCS Patient ID	Char	ID	Patient Identifier assigned by NCHS. Researchers requesting linked NHCS-CMS data should use PATIENT_ID.
PUBLICID	NHIS Public Use ID	Char	ID	Public-use survey participant identifier assigned by NCHS. Researchers requesting linked NHIS/LSOA II-Medicare data should use PUBLICID.
SEQN	NHANES Respondent Sequence Number	Num	ID	Public-use survey participant identifier assigned by NCHS. Researchers requesting linked NHEFS/NHANES III/NHANES-Medicare data should use SEQN.
RESNUM	NNHS Resident Record (Case) Number	Num	ID	Public-use survey participant identifier assigned by NCHS. Researchers requesting linked 2004 NNHS-Medicare data should use RESNUM.
SURVEY	Survey Name and survey year/cycle	Char		
FILE_YEAR4	Year of Medicare Fee-for-Service Claim (YYYY)	Num	2016-2018	2016 NHCS has been linked to only 2016-2017 Medicare Data.
NCHS_CLM_ID	NCHS CLAIM ID	Num		
NCH_NEAR_LINE_REC_IDENT_CD	NCH Near Line Record Identification Code (RIC)	Char	V	Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)
NCH_CLM_TYPE_CD	NCH Claim Type Code	Char	60	Inpatient claim
CLM_FROM_DT	Claim From Date	Num		Date provided in SAS date (numeric) format.
CLM_THRU_DT	Claim Through Date	Num		Date provided in SAS date (numeric) format.
NCH_WKLY_PROC_DT	NCH Weekly Claim Processing Date	Num		Date provided in SAS date (numeric) format.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
FI_CLM_PROC_DT	FI Claim Process Date	Num		Date provided in SAS date (numeric) format.
CLAIM_QUERY_CODE	Claim Query Code	Char	1	Interim bill
			3	Final bill
			5	Debit adjustment
PRVDR_NUM	Provider Number	Char		For value description please see website: https://www.resdac.org/cms-data/variables/provider-number (accessed on 06/22/2020)
CLM_FAC_TYPE_CD	Claim Facility Type Code	Char	1	Hospital
			4	Religious Nonmedical (Hospital) (eff. 8/1/00): prior to 8/00 referenced Christian Science (CS)
CLM_SRVC_CLSFCTN_TYPE_CD	Claim Service classification Type Code	Char	1	FAC_TYPE 1-6,9: Inpatient/FAC_TYPE 7: Rural Health Clinic (RHC)/ FAC_TYPE 8: Hospice (non-hospital based)
CLM_FREQ_CD	Claim Frequency Code	Char	0	Non-payment/zero claims
			1	Admit thru discharge claim
			2	Interim - first claim
			3	Interim - continuing claim
			4	Interim - last claim
			7	Replacement of prior claim
			G	CWF generated adjustment claim
			H	CMS generated adjustment claim
			I	Misc adjustment claim Misc. adjustment claim (e.g., initiated by intermediary or QIO)
			J	Other adjustment request

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			M	MSP adjustment
			P	Adjustment required by Quality Improvement Organization (QIO)
FI_NUM	FI or MAC Number	Char		For value description please see website: https://www.resdac.org/cms-data/variables/fi-or-mac-number (accessed on 06/22/2020)
CLM_MDCR_NON_PMT_RSN_CD	Claim Medicare Non Payment Reason Code	Char		Missing Value
			OTHER	Miscoded
			00	MSP cost avoided - COB Contractor
			12	MSP cost avoided - BCBS Voluntary Agreements
			19	SEE NOTE4: Coordination of Benefits Contractor 11119 (see CMS Change Request 7906 for identification of the contractor.)
			21	MSP cost avoided - MIR Group Health Plan (eff. 1/2009)
			22	MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009)
			42	SEE NOTE4: Coordination of Benefits Contractor 11142 (see CMS Change Request 7906 for identification of the contractor.)
			B	Benefit exhausted
			F	MSP cost avoid HMO Rate Cell (eff. 7/00)
			G	MSP cost avoided Litigation Settlement (eff. 7/00)
			H	MSP cost avoided Employer Voluntary Reporting (eff. 7/00)
			J	MSP cost avoid Insurer Voluntary Reporting (eff. 7/00)
			K	MSP cost avoid Initial Enrollment Questionnaire (eff. 7/00)
			N	All other reasons for nonpayment
			Q	MSP cost avoided Voluntary Agreement (eff. 7/00)
			R	Benefits refused, or evidence not submitted

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			T	MSP cost avoided - IEQ contractor (eff. 9/76) (obsolete 6/30/00)
			X	MSP cost avoided – generic
			Y	MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)
CLM_PMT_AMT	Claim (Medicare) Payment Amount	Num	0-2,749,500	Payment/Chagred Amount, in dollars.
NCH_PRMRY_PYR_CLM_PD_AMT	NCH Primary Payer (if not Medicare) Claim Paid Amount	Num	0-2,284,900	Payment/Chagred Amount, in dollars.
NCH_PRMRY_PYR_CD	NCH Primary Payer Code (if not Medicare)	Char		Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)
			A	Working aged bene/spouse with employer group health plan (EGHP)
			B	End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an employer group health plan
			C	Conditional payment by Medicare: future reimbursement expected
			D	Automobile no-fault (eff. 4/97: Prior to 3/94, also included any liability insurance)
			E	Workers` compensation
			G	Working disabled bene (under age 65 with LGHP)
			H	Black Lung
			I	Dept. of Veterans Affairs
			L	Any liability insurance (eff. 4/97) (eff. 12/90 for carrier claims and 10/93 for FI claims, obsoleted for all claim types 7/1/96)
			M	Override code: EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims, obsoleted for all claim types 7/1/96)
			N	Override code: non-EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims, obsoleted for all claim types 7/1/96)
FI_CLM_ACTN_CD	FI or MAC Claim Action Code	Char	1	Original debit action (always a 1 for all regular bills)

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			5	Force action code 3 (secondary debit adjustment)
			8	Benefits refused
PRVDR_STATE_CD	NCH Provider SSA State Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/ nch-provider-ssa-state-code (accessed on 06/22/2020)
ORG_NPI_NUM	Organization NPI Number	Char		
AT_PHYSN_UPIN	Claim Attending Physician UPIN Number	Char		
AT_PHYSN_NPI	Claim Attending Physician NPI Number	Char		
AT_PHYSN_SPCLTY_CD	Claim Attending Physician Specialty Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/ claim-attending-physician-specialty-code (accessed on 06/22/2020)
OP_PHYSN_UPIN	Claim Operating Physician UPIN Number	Char		
OP_PHYSN_NPI	Claim Operating Physician NPI Number	Char		
OP_PHYSN_SPCLTY_CD	Claim Operating Physician Specialty Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/ claim-operating-physician-specialty-code (accessed on 06/22/2020)
OT_PHYSN_UPIN	Claim Other Physician UPIN Number	Char		
OT_PHYSN_NPI	Claim Other Physician NPI Number	Char		
OT_PHYSN_SPCLTY_CD	Claim Other Physician Specialty Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/ claim-other-physician-specialty-code (accessed on 06/22/2020)

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
RNDRNG_PHYSN_NPI	Claim Rendering Physician NPI Number	Char		
RNDRNG_PHYSN_SPCLTY_CD	Claim Rendering Physician Specialty Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/ claim-or-revenue-center-rendering-physician-specialty-code (accessed on 06/22/2020)
CLM_MCO_PD_SW	Claim MCO Paid Switch	Char		No managed care organization (MCO) payment
			0	No managed care organization (MCO) payment
PTNT_DSCHRG_STUS_CD	Patient Discharge Status Code	Char	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.
			20	Expired (did not recover - Christian Science patient).
			21	Discharged/transferred to Court/Law Enforcement
			30	Still patient
			43	Discharged/transferred to a federal hospital (eff. 10/1/03)

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			50	Hospice - home (eff. 10/96)
			51	Hospice - medical facility (eff. 10/96)
			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 (eff. 10/2013)
			70	Discharged/transferred to another type of health care institution not defined elsewhere in code list.
			81	Discharged to home or self-care with a planned acute care hospital readmission (eff. 10/2013)
			82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (eff. 10/2013)
			83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (eff. 10/2013)
			84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (eff. 10/2013)

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			85	Discharged/transferred to a designated cancer center or childrens hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
			86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (eff. 10/2013)
			87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (eff. 10/2013)
			88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (eff. 10/2013)
			89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (eff. 10/2013)
			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 (eff. 10/2013)
			91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (eff. 10/2103)
			92	Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (eff. 10/2013)
			93	Discharged/transferred to a psychiatric hospital/distinct part unit of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
			94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (eff. 10/2013)
			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 (eff. 10/2013)
CLM_PPS_IND_CD	Claim PPS Indicator Code	Char		Missing Value
			2	PPS bill (claim contains PPS indicator but no deemed insured MQGE status indicator)

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
CLM_TOT_CHRG_AMT	Claim Total Charge Amount	Num	0-22,092,800	Payment/Chagred Amount, in dollars.
CLM_ADMSN_DT	Claim Admission Date	Num		Date provided in SAS date (numeric) format.
CLM_IP_ADMSN_TYPE_CD	Claim Inpatient Admission Type Code	Char		
CLM_SRC_IP_ADMSN_CD	Claim Source Inpatient Admission Code	Char		
NCH_PTNT_STATUS_IND_CD	NCH Patient Status Indicator Code	Char	A	Discharged
			B	Died
			C	Still patient
CLM_PASS_THRU_PER_DIEM_AMT	Claim Pass Thru Per Diem Amount	Num	0-6,900	Payment/Chagred Amount, in dollars.
NCH_BENE_IP_DDCTBL_AMT	NCH Beneficiary Inpatient (or other Part A) Deductible Amount	Num	0-1,400	Payment/Chagred Amount, in dollars.
NCH_BENE_PTA_COINSRNC_LBLTY_AM	NCH Beneficiary Part A Coinsurance Liability Amount	Num	0-10,400	Payment/Chagred Amount, in dollars.
NCH_BENE_BLOOD_DDCTBL_LBLTY_AM	NCH Beneficiary Blood Deductible Liability Amount	Num	0-2,000	Payment/Chagred Amount, in dollars.
NCH_PROFNL_CMPNT_CHRG_AMT	NCH Professional Component Charge Amount	Num	0-128,000	Payment/Chagred Amount, in dollars.
NCH_IP_NCVRD_CHRG_AMT	NCH Inpatient (or other Part A) Noncovered Charge Amount	Num	0-9,343,400	Payment/Chagred Amount, in dollars.
NCH_IP_TOT_DDCTN_AMT	NCH Inpatient (or other Part A) Total Deductible/Coinsurance Amount	Num	0-50,700	Payment/Chagred Amount, in dollars.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
CLM_TOT_PPS_CPTL_AMT	Claim Total PPS Capital Amount	Num	0-115,300	Payment/Chagred Amount, in dollars.
CLM_PPS_CPTL_FSP_AMT	Claim PPS Capital Federal Specific Portion (FSP) Amount	Num	0-17,600	Payment/Chagred Amount, in dollars.
CLM_PPS_CPTL_OUTLIER_AMT	Claim PPS Capital Outlier Amount	Num	0-102,600	Payment/Chagred Amount, in dollars.
CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT	Claim PPS Capital Disproportionate Share (DSH) Amount	Num	0-2,700	Payment/Chagred Amount, in dollars.
CLM_PPS_CPTL_IME_AMT	Claim PPS Capital Indirect Medical Education (IME) Amount	Num	0-6,700	Payment/Chagred Amount, in dollars.
CLM_PPS_CPTL_EXCPTN_AMT	Claim PPS Capital Exception Amount	Num	0-100	Payment/Chagred Amount, in dollars.
CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT	Claim PPS Old Capital Hold Harmless Amount	Num		Payment/Chagred Amount, in dollars.
CLM_PPS_CPTL_DRG_WT_NUM	Claim PPS Capital DRG Weight Number	Num	0-27.1	
CLM_UTLZTN_DAY_CNT	Claim Medicare Utilization Day Count	Num	0-200	Number of days (count)
BENE_TOT_COINSRNC_DAYS_CNT	Beneficiary Total Coinsurance Days Count	Num	0-100	Number of days (count)
BENE_LRD_USED_CNT	Beneficiary Medicare Lifetime Reserve Days (LRD) Used Count	Num	0-100	Number of days (count)
CLM_NON_UTLZTN_DAYS_CNT	Claim Medicare Non Utilization Days Count	Num	0-1,700	Number of days (count)
NCH_BLOOD_PNTS_FRNSHD_QTY	NCH Blood Pints Furnished Quantity	Num	0-933	

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
NCH_VRFD_NCVRD_STAY_FROM_DT	NCH Verified Noncovered Stay From Date	Num		Date provided in SAS date (numeric) format.
NCH_VRFD_NCVRD_STAY_THRU_DT	NCH Verified Noncovered Stay Through Date	Num		Date provided in SAS date (numeric) format.
NCH_ACTV_OR_CVRD_LVL_CARE_THRU	NCH Active or Covered Level Care Thru Date	Num		Date provided in SAS date (numeric) format.
NCH_BENE_MDCR_BNFTS_EXHTD_DT_I	NCH Beneficiary Medicare Benefits Exhausted Date	Num		Date provided in SAS date (numeric) format.
NCH_BENE_DSCHRG_DT	NCH Beneficiary Discharge Date	Num		Date provided in SAS date (numeric) format.
CLM_DRG_CD	Claim Diagnosis Related Group Code (or MS-DRG Code)	Char		For value description please see website: https://www.resdac.org/cms-data/variables/ claim-diagnosis-related-group-code-or-ms-drg-code-0 (accessed on 06/22/2020)
CLM_DRG_OUTLIER_STAY_CD	Claim Diagnosis Related Group Outlier Stay Code	Char	0	No outlier
			2	Cost outlier (condition code 61)
			6	Non-PPS Only: Valid diagnosis related groups (DRG) received from the intermediary
			8	Non-PPS Only: CMS developed DRG using patient status code
NCH_DRG_OUTLIER_APRVD_PMT_AMT	NCH DRG Outlier Approved Payment Amount	Num	0-1,176,400	Payment/Chagred Amount, in dollars.
ADMTG_DGNS_CD	Claim Admitting Diagnosis Code	Char		
PRNCPAL_DGNS_CD	Claim Principal Diagnosis Code	Char		
ICD_DGNS_CD1	Claim Diagnosis Code I	Char		

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
CLM_POA_IND_SW1	Claim Diagnosis Code I Diagnosis Present on Admission (POA) Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD2	Claim Diagnosis Code II	Char		
CLM_POA_IND_SW2	Claim Diagnosis Code II Diagnosis Present on Admission (POA) Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD3	Claim Diagnosis Code III	Char		
CLM_POA_IND_SW3	Claim Diagnosis Code III Diagnosis Present on Admission (POA) Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD4	Claim Diagnosis Code IV	Char		
CLM_POA_IND_SW4	Claim Diagnosis Code IV Diagnosis Present on Admission (POA) Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD5	Claim Diagnosis Code V	Char		
CLM_POA_IND_SW5	Claim Diagnosis Code V Diagnosis Present on Admission (POA) Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD6	Claim Diagnosis Code VI	Char		
CLM_POA_IND_SW6	Claim Diagnosis Code VI Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.

[1]The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD7	Claim Diagnosis Code VII	Char		
CLM_POA_IND_SW7	Claim Diagnosis Code VII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.

[1]The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.

NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Inpatient Fee-For-Service Base Claims
Date Created: 29JAN2021
Number of Variables: 249

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_DGNS_CD8	Claim Diagnosis Code VIII	Char		
CLM_POA_IND_SW8	Claim Diagnosis Code VIII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD9	Claim Diagnosis Code IX	Char		
CLM_POA_IND_SW9	Claim Diagnosis Code IX Diagnosis Present on Admission Indicator Code	Char		Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.

[1]**The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.**

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD10	Claim Diagnosis Code X	Char		
CLM_POA_IND_SW10	Claim Diagnosis Code X Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.

[1] **The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.**

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD11	Claim Diagnosis Code XI	Char		
CLM_POA_IND_SW11	Claim Diagnosis Code XI Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.

[1]**The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.**

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_DGNS_CD12	Claim Diagnosis Code XII	Char		
CLM_POA_IND_SW12	Claim Diagnosis Code XII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD13	Claim Diagnosis Code XIII	Char		
CLM_POA_IND_SW13	Claim Diagnosis Code XIII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.

[1]**The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.**

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD14	Claim Diagnosis Code XIV	Char		
CLM_POA_IND_SW14	Claim Diagnosis Code XIV Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.

[1]**The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.**

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as \`Y\` for the POA Indicator.
ICD_DGNS_CD15	Claim Diagnosis Code XV	Char		
CLM_POA_IND_SW15	Claim Diagnosis Code XV Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the \`1\`). NOTE: NCH/NMUD will carry a \`0\` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as \`Y\` for the POA Indicator.

[1]The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.

NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Inpatient Fee-For-Service Base Claims
Date Created: 29JAN2021
Number of Variables: 249

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_DGNS_CD16	Claim Diagnosis Code XVI	Char		
CLM_POA_IND_SW16	Claim Diagnosis Code XVI Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD17	Claim Diagnosis Code XVII	Char		
CLM_POA_IND_SW17	Claim Diagnosis Code XVII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.

[1]The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD18	Claim Diagnosis Code XVIII	Char		
CLM_POA_IND_SW18	Claim Diagnosis Code XVIII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.

[1]**The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.**

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as \`Y\` for the POA Indicator.
ICD_DGNS_CD19	Claim Diagnosis Code XIX	Char		
CLM_POA_IND_SW19	Claim Diagnosis Code XIX Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the \`1\`). NOTE: NCH/NMUD will carry a \`0\` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as \`Y\` for the POA Indicator.

[1]The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.

NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Inpatient Fee-For-Service Base Claims
Date Created: 29JAN2021
Number of Variables: 249

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_DGNS_CD20	Claim Diagnosis Code XX	Char		
CLM_POA_IND_SW20	Claim Diagnosis Code XX Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD21	Claim Diagnosis Code XXI	Char		
CLM_POA_IND_SW21	Claim Diagnosis Code XXI Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.

[1]The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD22	Claim Diagnosis Code XXII	Char		
CLM_POA_IND_SW22	Claim Diagnosis Code XXII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.

[1]The range of values field contain approximate values for the payment, cost, and count variables. The actual values may include extreme outliers (positive or negative). Users may wish to consider applying top or bottom coding.

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD23	Claim Diagnosis Code XXIII	Char		
CLM_POA_IND_SW23	Claim Diagnosis Code XXIII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_DGNS_CD24	Claim Diagnosis Code XXIV	Char		
CLM_POA_IND_SW24	Claim Diagnosis Code XXIV Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
ICD_DGNS_CD25	Claim Diagnosis Code XXV	Char		
CLM_POA_IND_SW25	Claim Diagnosis Code XXV Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			1	Unreported/not used -- exempt from POA reporting -- This code is equivalent to a blank pn the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA Indicator. The “1” POA Indicator should not be applied to any codes on the HAC list.
			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.
			Y	Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as `Y` for the POA Indicator.
FST_DGNS_E_CD	First Claim Diagnosis E Code	Char		
ICD_DGNS_E_CD1	Claim Diagnosis E Code I	Char		
CLM_E_POA_IND_SW1	Claim Diagnosis E Code I Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD2	Claim Diagnosis E Code II	Char		
CLM_E_POA_IND_SW2	Claim Diagnosis E Code II Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_DGNS_E_CD3	Claim Diagnosis E Code III	Char		
CLM_E_POA_IND_SW3	Claim Diagnosis E Code III Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD4	Claim Diagnosis E Code IV	Char		
CLM_E_POA_IND_SW4	Claim Diagnosis E Code IV Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD5	Claim Diagnosis E Code V	Char		
CLM_E_POA_IND_SW5	Claim Diagnosis E Code V Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD6	Claim Diagnosis E Code VI	Char		
CLM_E_POA_IND_SW6	Claim Diagnosis E Code VI Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD7	Claim Diagnosis E Code VII	Char		
CLM_E_POA_IND_SW7	Claim Diagnosis E Code VII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD8	Claim Diagnosis E Code VIII	Char		

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
CLM_E_POA_IND_SW8	Claim Diagnosis E Code VIII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD9	Claim Diagnosis E Code IX	Char		
CLM_E_POA_IND_SW9	Claim Diagnosis E Code IX Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD10	Claim Diagnosis E Code X	Char		
CLM_E_POA_IND_SW10	Claim Diagnosis E Code X Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD11	Claim Diagnosis E Code XI	Char		
CLM_E_POA_IND_SW11	Claim Diagnosis E Code XI Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_DGNS_E_CD12	Claim Diagnosis E Code XII	Char		
CLM_E_POA_IND_SW12	Claim Diagnosis E Code XII Diagnosis Present on Admission Indicator Code	Char	0	Identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the `1`). NOTE: NCH/NMUD will carry a `0` in place of a blank.
ICD_PRCDR_CD1	Claim Procedure Code I	Char		
PRCDR_DT1	Claim Procedure Code I Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD2	Claim Procedure Code II	Char		

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
PRCDR_DT2	Claim Procedure Code II Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD3	Claim Procedure Code III	Char		
PRCDR_DT3	Claim Procedure Code III Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD4	Claim Procedure Code IV	Char		
PRCDR_DT4	Claim Procedure Code IV Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD5	Claim Procedure Code V	Char		
PRCDR_DT5	Claim Procedure Code V Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD6	Claim Procedure Code VI	Char		
PRCDR_DT6	Claim Procedure Code VI Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD7	Claim Procedure Code VII	Char		
PRCDR_DT7	Claim Procedure CodeVII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD8	Claim Procedure Code VIII	Char		
PRCDR_DT8	Claim Procedure Code VIII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD9	Claim Procedure Code IX	Char		
PRCDR_DT9	Claim Procedure Code IX Date	Num		Date provided in SAS date (numeric) format.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_PRCDR_CD10	Claim Procedure Code X	Char		
PRCDR_DT10	Claim Procedure Code X Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD11	Claim Procedure Code XI	Char		
PRCDR_DT11	Claim Procedure Code XI Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD12	Claim Procedure Code XII	Char		
PRCDR_DT12	Claim Procedure Code XII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD13	Claim Procedure Code XIII	Char		
PRCDR_DT13	Claim Procedure Code XIII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD14	Claim Procedure Code XIV	Char		
PRCDR_DT14	Claim Procedure Code XIV Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD15	Claim Procedure Code XV	Char		
PRCDR_DT15	Claim Procedure Code XV Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD16	Claim Procedure Code XVI	Char		
PRCDR_DT16	Claim Procedure Code XVI Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD17	Claim Procedure Code XVII	Char		

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
PRCDR_DT17	Claim Procedure Code XVII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD18	Claim Procedure Code XVIII	Char		
PRCDR_DT18	Claim Procedure Code XVIII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD19	Claim Procedure Code XIX	Char		
PRCDR_DT19	Claim Procedure Code XIX Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD20	Claim Procedure Code XX	Char		
PRCDR_DT20	Claim Procedure Code XX Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD21	Claim Procedure Code XXI	Char		
PRCDR_DT21	Claim Procedure Code XXI Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD22	Claim Procedure Code XXII	Char		
PRCDR_DT22	Claim Procedure Code XXII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD23	Claim Procedure Code XXIII	Char		
PRCDR_DT23	Claim Procedure Code XXIII Date	Num		Date provided in SAS date (numeric) format.
ICD_PRCDR_CD24	Claim Procedure Code XXIV	Char		
PRCDR_DT24	Claim Procedure Code XXIV Date	Num		Date provided in SAS date (numeric) format.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
ICD_PRCDR_CD25	Claim Procedure Code XXV	Char		
PRCDR_DT25	Claim Procedure Code XXV Date	Num		Date provided in SAS date (numeric) format.
IME_OP_CLM_VAL_AMT	Operating Indirect Medical Education (IME) Amount	Num	0-109,800	Payment/Chagred Amount, in dollars.
DSH_OP_CLM_VAL_AMT	Operating Disproportionate Share Amount	Num	0-25,600	Payment/Chagred Amount, in dollars.
DOB_DT	Date of Birth from Claim	Num		Date provided in SAS date (numeric) format.
GNDR_CD	Gender Code from Claim	Char	1	Male
			2	Female
BENE_RACE_CD	Race Code from Claim	Char	0	Unknown
			1	White
			2	Black
			3	Other
			4	Asian/Pacific Islander
			5	Hispanic
			6	North American Native
BENE_CNTY_CD	Beneficiary County Code from Claim (SSA)	Char		
BENE_STATE_CD	Beneficiary Residence (SSA) State Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/beneficiary-residence-ssa-state-code-ffs (accessed on 06/22/2020)

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NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Inpatient Fee-For-Service Base Claims
Date Created: 29JAN2021
Number of Variables: 249

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
BENE_MLG_CNTCT_ZIP_CD	Beneficiary ZIP Code of Residence	Char		
CLM_MDCL_REC	Claim Medical Record Number	Char		Missing Value
CLM_TRTMT_AUTHRZTN_NUM	Claim Treatment Authorization Number	Char		
CLM_PRCR_RTRN_CD	Claim Pricer Return Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/claim-pricer-return-code (accessed on 06/22/2020)
CLM_SRVC_FAC_ZIP_CD	Claim service facility ZIP code (where service was provided)	Char		
CLM_IP_LOW_VOL_PMT_AMT	Claim Inpatient Low Volume Payment Amount	Num	0-13,500	Payment/Chagred Amount, in dollars.
CLM_CARE_IMPRVMT_MODEL_CD1	Claim Care Improvement Model 1 Code (budled payment)	Char		Not using model
			61	Care Improvement Model 1 is used
CLM_CARE_IMPRVMT_MODEL_CD2	Claim Care Improvement Model 2 Code	Char		Not using model
			62	Care Improvement Model 2 is used
CLM_CARE_IMPRVMT_MODEL_CD3	Claim Care Improvement Model 3 Code	Char		Not using model
CLM_CARE_IMPRVMT_MODEL_CD4	Claim Care Improvement Model 4 Code	Char		Not using model
			64	Care Improvement Model 4 is used
CLM_BNDLD_MODEL_1_DSCNT_PCT	Claim Bundled Model 1 Discount Percent	Num	0-0.01	
CLM_BASE_OPRTG_DRG_AMT	Claim Base Operating DRG Amount	Num	0-223,900	Payment/Chagred Amount, in dollars.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
CLM_VBP_PRTCPNT_IND_CD	Claim Value-Based Purchasing (VBP) Participant Indicator Code	Char		Not participating in Hospital Value Based Purchasing
			N	Not participating in Hospital Value Based Purchasing
			Y	Participating in Hospital Value Based Purchasing
CLM_VBP_ADJSTMT_PCT	Claim VBP Adjustment Percent	Num	0-1.04	
CLM_HRR_PRTCPNT_IND_CD	Claim Hospital Readmission Rdctn (HRR) Participant Indicator Code	Char		Not participating
			0	Not participating
			1	Participating and not equal to 1.0000
CLM_HRR_ADJSTMT_PCT	Claim HRR Adjustment Percent	Num	0-1	
CLM_MODEL_4_READMSN_IND_CD	Claim Model 4 Readmission Indicator Code	Char		Not a BPCI claim
			1	Claim is related readmission to a Model 4 BPCI claim and shall pay IME, DSH, and Capital Only.
			2	Two Model 4 BPCI claims within 30 days of each other, first claim in episode shall process as it would in the absence of Model 4 BPCI.
CLM_UNCOMPD_CARE_PMT_AMT	Claim Uncompensated Care Payment Amount	Num	0-77,500	Payment/Chagred Amount, in dollars.
CLM_BNDLD_ADJSTMT_PMT_AMT	Claim Bundled Adjustment Payment Amount	Num		Payment/Chagred Amount, in dollars.
CLM_VBP_ADJSTMT_PMT_AMT	Claim Value Based Purchasing Adjustment Payment Amount	Num	0-2,300	Payment/Chagred Amount, in dollars.
CLM_HRR_ADJSTMT_PMT_AMT	Claim Hospital Readmission Reduction (HRR) Adjustment Payment Amount	Num		Payment/Chagred Amount, in dollars.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
EHR_PYMT_ADJSTMT_AMT	Claim Electronic Health Record (EHR) Payment Adjustment Amount	Num	0-2,900	Payment/Chagred Amount, in dollars.
PPS_STD_VAL_PYMT_AMT	Standard Payment Amount	Num	0-1,208,100	Payment/Chagred Amount, in dollars.
FINL_STD_AMT	Claim Final Standard Payment Amount	Num	0-2,754,100	Payment/Chagred Amount, in dollars.
HAC_PGM_RDCTN_IND_SW	Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Switch	Char		Missing Value
EHR_PGM_RDCTN_IND_SW	Claim Electronic Health Records (EHR) Program Reduction Indicator Switch	Char		Not applicable
CLM_SITE_NTRL_PYMT_CST_AMT	Claim Site Neutral Payment Based on Cost Amount	Num	0-27,200	Payment/Chagred Amount, in dollars.
CLM_SITE_NTRL_PYMT_IPPS_AMT	Claim Site Neutral Payment Based on inpatient prospective payment system (IPPS) Amounts	Num	0-49,600	Payment/Chagred Amount, in dollars.
CLM_FULL_STD_PYMT_AMT	Claim Full Standard Payment Amount	Num	0-192,200	Payment/Chagred Amount, in dollars.
CLM_SS_OUTLIER_STD_PYMT_AMT	Claim Short Stay Outlier (SSO) Standard Payment Amount	Num	0-107,200	Payment/Chagred Amount, in dollars.
CLM_NEXT_GNRTN_ACO_IND_CD1	Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code - Population based payments (PBP)	Char		Missing Value
			5	Capitation
CLM_NEXT_GNRTN_ACO_IND_CD2	Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code - Telehealth	Char		Missing Value

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Inpatient Fee-For-Service Base Claims
Date Created: 29JAN2021
Number of Variables: 249

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
CLM_NEXT_GNRTN_ACO_IND_CD3	Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code - Post Discharge HH visits	Char		Missing Value
CLM_NEXT_GNRTN_ACO_IND_CD4	Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code - 3 day SNF waiver	Char		Missing Value
CLM_NEXT_GNRTN_ACO_IND_CD5	Claim Next Generation (NG) Accountable Care Organization (ACO) Indicator Code - Capitation	Char		Missing Value
ACO_ID_NUM	Claim Accountable Care Organization (ACO) Identification Number	Char		
CLM_BENE_ID_TYPE_CD	Claim Beneficiary Identifier Type Code (For CMS Internal Use)	Char		
CLM_RSDL_PYMT_IND_CD	Claim Residual Payment Indicator Code	Char		Missing Value
			X	Residual payment
CLM_RP_IND_CD	Claim Representative Payee (RP) Indicator Code	Char		Missing Value
PRVDR_VLDTN_TYPE_CD	Provider Validation Type Code	Char		Missing Value
RR_BRD_EXCLSN_IND_SW	Railroad Board Exclusion Indicator Switch	Char		Subject RRB beneficiary services to prior authorization
CLM_IP_INITL_MS_DRG_CD	Claim Inpatient Initial MS DRG Code	Char		For value description please see website: https://www.resdac.org/cms-data/variables/ claim-inpatient-initial-ms-drg-code (accessed on 06/22/2020)

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