2015 Researcher’s Guide to the USRDS Database
## Table of Contents

Preface........................................................................................................................................... 1
Acknowledgments ................................................................................................................................ 1
USRDS Coordinating Center ............................................................................................................ 1
NIDDK Project Officers .................................................................................................................. 1
Suggested Citation ............................................................................................................................. 2
Introduction .......................................................................................................................................... 2

- USRDS website: www.usrds.org ....................................................................................................... 2
- Requesting Data ................................................................................................................................ 2
- RenDER .............................................................................................................................................. 2
- What’s New in 2015 .......................................................................................................................... 3
- New 2015 SAF Files .......................................................................................................................... 3
- Changes to 2015 SAFs ...................................................................................................................... 6

Getting Started .................................................................................................................................... 16

- Basic SAS Use .................................................................................................................................. 17
- SAS Formats for USRDS Data .......................................................................................................... 18
- Comment Lines ............................................................................................................................... 19
- The SAF Directory .......................................................................................................................... 19

SAS Examples ....................................................................................................................................... 20

- Example 1: Patient Cohort Included in USRDS Annual Data Report (ADR) ................................... 20
- Example 2: Incident Cohort .............................................................................................................. 20
- Example 3: Incident Patient Distribution by Demographic Data ....................................................... 21
- Example 4: Point Prevalent Cohort ................................................................................................. 21
- Example 5: 2005 Incident Patient Survival Rates (Kaplan-Meier) .................................................. 21
- Example 6: Merge With Medical Evidence file (CMS 2728) ........................................................... 22
- Example 7: 2008 Incident Patient Survival Rates (Kaplan-Meier) .................................................. 22
- Example 8: Waiting List Access Rate ............................................................................................. 23
- Example 9: Create a Patient Cohort of 2008 Medicare Primary Incident Patients ........................ 24
- Example 10: Total Admission Rate ............................................................................................... 24
- Example 11: First Admission Rate .................................................................................................. 26
- Example 12: Total Cost and Cost by Service Type ....................................................................... 28

Methods & Databases ....................................................................................................................... 29

Section 1: ESRD Data and the USRDS ESRD Database ....................................................................... 29

- Data Sources .................................................................................................................................... 29

Section 2: ESRD Patients ..................................................................................................................... 37

- Identifying ESRD Patients ................................................................................................................ 37
- First ESRD Service Date .................................................................................................................. 38
- Death Date Determination .............................................................................................................. 38
- Transplant Dates ............................................................................................................................. 39
- Graft Failure ..................................................................................................................................... 39
- Medicare and Non-Medicare Patients ............................................................................................. 40

Section 3: Treatment History .............................................................................................................. 41

- Treatment Modality Categories ....................................................................................................... 41
- How Treatment Modality is Determined ......................................................................................... 42
Preface

The Researcher’s Guide is intended for investigators within and outside of the United States Renal Data System (USRDS) Coordinating Center (CC) who wish to undertake research projects using data from the USRDS database. This guide places particular emphasis on the USRDS Standard Analysis File (SAF) dataset, the primary means by which USRDS data are made available for use. The Researcher’s Guide includes information needed to help researchers select and use the appropriate SAFs for the intended project.

Acknowledgments

Most of the original data for the USRDS end-stage renal disease (ESRD) database are provided by the Centers for Medicare & Medicaid Services (CMS) through the inter-agency agreement between the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) / Division of Kidney, Urologic, and Hematologic Diseases (DKUHD) of the National Institutes of Health (NIH), and the CMS Bureau of Data Management and Strategy. The USRDS offers its grateful appreciation to everyone who contributed to the USRDS database and to this guide, especially all the ESRD professionals and Networks who report the data included in the ESRD database.

USRDS Coordinating Center

- Director: Rajiv Saran, MBBS, DTCD, MD, MRCP, MS
- Co-Deputy Director: Yi Li, PhD
- Co-Deputy Director: Bruce Robinson, MD, MS, FACP

NIDDK Project Officers

- Kevin C. Abbott, MD, MPH — Director, Kidney and Urology Epidemiology, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH)
- Lawrence Y. C. Agodoa, MD — Director, End-stage Renal Disease Program, Division of Kidney, Urologic, and Hematologic Diseases (DKUHD), NIH
- Paul W. Eggers, PhD — NIDDK, NIH
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Publications based upon USRDS data must include the following disclaimer: “The data reported here have been supplied by the United States Renal Data System (USRDS). The interpretation and reporting of these data are the responsibility of the author(s) and in no way should be seen as an official policy or interpretation of the U.S. government.”

Publications based upon USRDS data must also be submitted for privacy assurance to the USRDS Program Officer at NIDDK, kevin.abbott@nih.gov, with the subject line subject: “USRDS manuscript.” Requests should also include the approved Data Use Agreement number.

Introduction

USRDS website: www.usrds.org

The USRDS website provides users with access to the Annual Data Report (ADR), which is available in HTML and downloadable PDF, Excel, and PowerPoint files. ADR chapters and volumes are available in PDF; Reference Tables and the data underlying the figures and tables for each chapter are available in Excel; and, all chapter figures and tables are available in PowerPoint slides. Because of the file size, downloading some portions of the ADR may require user patience.

Requesting Data

A primary objective of the USRDS is to make data available to the renal community. Detailed information on how to request data can be found at http://www.usrds.org/request.aspx.

RenDER

The USRDS Renal Data Extraction and Referencing (RenDER) System is an online data querying application accessible through the USRDS website. RenDER provides access to a wealth of information regarding end-stage renal disease (ESRD) in the United States. It quickly returns an accurate table of data or an interactive map based on the user’s query specifications. Tables can be copied into a spreadsheet application on the user’s computer for further manipulation and investigation, and map images can be copied and saved to local applications. A database file
download of the mapped data, which can be opened or imported by most spreadsheet applications, is also available.

The RenDER System allows easy access to some of the most frequently requested data. While the ADR thoroughly covers many ESRD statistics, it cannot reasonably contain the more detailed tables often requested by researchers. RenDER allows users to drill down into the data behind many of the tables published in the ADR, allowing crosstabulation among various demographic variables. To access the RenDER tutorial, visit www.usrds.org/render/xrender_home.asp.

What’s New in 2015

New 2015 SAF Files

The following files are new to the USRDS ESRD database this year.

**CROWNWeb Clinical Data SAF**

In 2015, CROWNWeb has become an integral part of the USRDS SAFs. CROWNWeb collects administrative and clinical data from all Medicare-certified dialysis facilities in the United States. It includes patient admission, tracking, and discharge information, CMS forms, and clinical data elements. Monthly clinical data submission began in May 2012. Previously, monthly clinical data were available to the USRDS for Medicare patients only through administrative claims. The 2015 USRDS CROWNWeb Clinical Data SAF includes data collected from May 2012 to December 2014. Facilities are asked to submit patient clinical information each month. The last values for a month are required to be entered by the end of the following month. For example, labs drawn in August should be entered by the end of September. There are out-of-range values in some variables, therefore, users should be cautious with out-of-range values when conducting analyses.

Table 1 lists the clinical measures included in the 2015 CROWNWeb Clinical Data SAF, except for the patient information variables USRDS_ID, REPORT_MONTH_YEAR (year and month the record was reported) and PROVUSRDS (USRDS assigned Facility ID). Detailed information for these variables can be found in Appendix B: Data File Descriptions.
### Table 1. Data sources and variables in the CROWNWeb Clinical Data SAF

<table>
<thead>
<tr>
<th>Data source</th>
<th>Measure name</th>
<th>Variable name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis Adequacy</td>
<td>Kt/V</td>
<td>HD_KTV</td>
</tr>
<tr>
<td></td>
<td>Normalized Protein Catabolic Rate (nPCR)</td>
<td>HD_NPCR</td>
</tr>
<tr>
<td></td>
<td>Delivered Minutes</td>
<td>HD_DELIVERED_MINS</td>
</tr>
<tr>
<td></td>
<td>Pre-dialysis Weight</td>
<td>HD_WEIGHT_PRE</td>
</tr>
<tr>
<td></td>
<td>Post-dialysis Weight</td>
<td>HD_WEIGHT_POST</td>
</tr>
<tr>
<td>Peritoneal Dialysis Adequacy</td>
<td>Kt/V</td>
<td>PD_KTV</td>
</tr>
<tr>
<td></td>
<td>Normalized Protein Catabolic Rate (nPCR)</td>
<td>PD_NPCR</td>
</tr>
<tr>
<td></td>
<td>Weight</td>
<td>PD_WEIGHT</td>
</tr>
<tr>
<td>Anemia Management</td>
<td>Hemoglobin</td>
<td>HGB</td>
</tr>
<tr>
<td></td>
<td>ESA Administered</td>
<td>ESA_ADMINISTERED_ID</td>
</tr>
<tr>
<td></td>
<td>Reticulocyte Hemoglobin Content (Chr)</td>
<td>CHR</td>
</tr>
<tr>
<td></td>
<td>Transferrin Saturation (TSAT)</td>
<td>IRON_SAT_PERCENT</td>
</tr>
<tr>
<td></td>
<td>Ferritin</td>
<td>FERRITIN</td>
</tr>
<tr>
<td>Iron</td>
<td>Intravenous Iron Administered</td>
<td>IRON_IV_ADMINISTERED_ID</td>
</tr>
<tr>
<td></td>
<td>Oral Iron Prescribed</td>
<td>IRON_ORAL_PRESCRIBED_ID</td>
</tr>
<tr>
<td>Mineral Metabolism</td>
<td>Phosphorous</td>
<td>PHOSPHORUS</td>
</tr>
<tr>
<td></td>
<td>Calcium Uncorrected</td>
<td>CALCIAL_UNCORRECTED</td>
</tr>
<tr>
<td></td>
<td>Calcium Corrected</td>
<td>CALCIAL_CORRECTED</td>
</tr>
<tr>
<td></td>
<td>Serum albumin</td>
<td>ALBUMIN</td>
</tr>
<tr>
<td>Vascular Access</td>
<td>Access Type</td>
<td>ACCESS_TYPE_ID</td>
</tr>
</tbody>
</table>

**MEDICARE CLAIMS CLINICAL DATA SAF**

The Medicare Claims Clinical Data SAF includes the revenue center details, diagnoses, and procedures on each claim that specifically indicate dialysis claims, which are extracted from Institutional Claims SAF Files (Outpatient, Inpatient, Home Health Agency, Skilled Nursing Facility, Hospice). The diagnoses can be identified by the International Classification of Diseases (ICD) diagnosis codes; and the procedures can be identified by the ICD procedure codes and Current Procedural Terminology, 4th Edition [CPT-4] codes. CPT-4 codes only appear under the Healthcare Common Procedure Coding System (HCPCS) codes in the Revenue Center Details Files (see more about HCPCS in the section titled *Institutional Claims Details and Revenue Center Details*). Billing details were summarized and merged back with the claim-level file – one record per claim in the Medicare Claims Clinical Data SAF. 2011-2013 data are included in the Medicare claims clinical data for 2015. Each year contains approximately 4 million records at the month/year claim level. The variables included in the Medicare claims clinical outcomes data are listed in Table 2. Information for these variables can also be found in Appendix B: Data File Descriptions.
Table 2. Variables in the Medicare Claims Clinical Data SAF

<table>
<thead>
<tr>
<th>Variable</th>
<th>Type</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART_FISTULA</td>
<td>Char</td>
<td>Has fistula modifier</td>
</tr>
<tr>
<td>ART_GRAFT</td>
<td>Char</td>
<td>Has graft modifier</td>
</tr>
<tr>
<td>CAPD_SESS</td>
<td>Num</td>
<td>Number of continuous ambulatory peritoneal dialysis sessions</td>
</tr>
<tr>
<td>CCPD_SESS</td>
<td>Num</td>
<td>Number of continuous cycling peritoneal dialysis sessions</td>
</tr>
<tr>
<td>CLM_FROM</td>
<td>Num</td>
<td>From date of service</td>
</tr>
<tr>
<td>CLM_THRU</td>
<td>Num</td>
<td>Service through date</td>
</tr>
<tr>
<td>DARBOADMIN</td>
<td>Num</td>
<td>Darbo administration, count HCPCS in (J0881, J0882)</td>
</tr>
<tr>
<td>DARBODOSE</td>
<td>Num</td>
<td>Sum units where HCPCS in (J0881, J0882)</td>
</tr>
<tr>
<td>DIALSESS</td>
<td>Num</td>
<td>Dialysis sessions reported</td>
</tr>
<tr>
<td>EPOADMIN</td>
<td>Num</td>
<td>Number of EPO administrations summed from revenue center units (1000)</td>
</tr>
<tr>
<td>EPODOSE</td>
<td>Num</td>
<td>Total EPO dosage (units) for this claim</td>
</tr>
<tr>
<td>FERAHMEADMIN</td>
<td>Num</td>
<td>Count HCPCS in (Q0139)</td>
</tr>
<tr>
<td>HCFASAF</td>
<td>Char</td>
<td>HCFA SAF source of this bill</td>
</tr>
<tr>
<td>HCRIT</td>
<td>Num</td>
<td>HEMATOCRIT reported on ESA claim</td>
</tr>
<tr>
<td>HD_SESS</td>
<td>Num</td>
<td>Number of hemodialysis sessions</td>
</tr>
<tr>
<td>HEIGHT</td>
<td>Num</td>
<td>Height value from claim value trailers (centimeter)</td>
</tr>
<tr>
<td>HEMOGLOBIN</td>
<td>Num</td>
<td>First hemoglobin value from claim value trailers</td>
</tr>
<tr>
<td>IRONDADMIN</td>
<td>Num</td>
<td>Count HCPCS in (J1750,J1760,J1751,J1752)</td>
</tr>
<tr>
<td>KTV</td>
<td>Num</td>
<td>Kt/V</td>
</tr>
<tr>
<td>KTV_OCC_DT</td>
<td>Num</td>
<td>Date of Kt/V measurement if claim related occurrence=51</td>
</tr>
<tr>
<td>PD_HOURS</td>
<td>Num</td>
<td>The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home)</td>
</tr>
<tr>
<td>PD_SESS</td>
<td>Num</td>
<td>Number of other peritoneal dialysis sessions</td>
</tr>
<tr>
<td>PROVUSRD</td>
<td>Num</td>
<td>USRDS assigned facility ID</td>
</tr>
<tr>
<td>RXCAT</td>
<td>Char</td>
<td>Dialysis type</td>
</tr>
<tr>
<td>SEQ_KEYC</td>
<td>Char</td>
<td>Sequence # to ensure unique key</td>
</tr>
<tr>
<td>TYPE_OF_BILL</td>
<td>Char</td>
<td>Bill type code</td>
</tr>
<tr>
<td>URR_CAT</td>
<td>Char</td>
<td>First URR HCPCS modifier for this claim</td>
</tr>
<tr>
<td>USRDS_ID</td>
<td>Num</td>
<td>USRDS patient ID number</td>
</tr>
<tr>
<td>VAS_CAT</td>
<td>Char</td>
<td>Has vascular access modifier</td>
</tr>
<tr>
<td>WEIGHT</td>
<td>Num</td>
<td>Weight value from claim value trailers (kilogram)</td>
</tr>
</tbody>
</table>

**ACTIVE ADIPOSE STUDY SAF**

Active Adipose is a cohort study to investigate the value of exercise in ESRD. The study is designed to examine the paradox of obesity and survival in ESRD. Active Adipose data are included in the 2015 SAFs. The files include a Master File, Body Composition data, Medical Record data, Medication data, Patient Questionnaire data, Physical Measures data, Spanish Form data, Hospitalization data, Institutional Claims, and Physician/Supplier Claims. The variable list for each of the files can be found in Appendix B: Data File Descriptions.
CLAIMS FILES FOR COMPREHENSIVE DIALYSIS STUDY SAF

Hospitalization Claims, Institutional Claims, and Physician/Supplier Claims for the Comprehensive Dialysis Study patients are included in the 2015 SAFs.

Changes to 2015 SAFs

Changes to the 2015 USRDS Standard Analysis Files (SAF) are listed below, and are explained in further detail in the What’s New in 2015 text file included with the Core SAF.

FILE NAME CHANGES

Some file names were changed in the 2015 SAFs. Table 3 lists files with name changes in the 2015 SAFs, along with the names of the corresponding files in the 2014 SAFs.

Table 3. Files with names changed in 2015 SAFs

<table>
<thead>
<tr>
<th>2014 SAF file names</th>
<th>2015 SAF file names</th>
</tr>
</thead>
<tbody>
<tr>
<td>INC2012a (for CKD)</td>
<td>CKD_INCLM_2013</td>
</tr>
<tr>
<td>DET2012a-f (for CKD)</td>
<td>CKD_INDETAI_2013</td>
</tr>
<tr>
<td>S2012a-g (for CKD)</td>
<td>CKD_PS_2013</td>
</tr>
<tr>
<td>HOSP1+HOSP2</td>
<td>HOSP_to2009</td>
</tr>
<tr>
<td>HOSP3</td>
<td>HOSP_2010on</td>
</tr>
<tr>
<td>HOSP1 (for DMMS)</td>
<td>DMMS_HOSP_to2009</td>
</tr>
<tr>
<td>HOSP2 (for DMMS)</td>
<td>DMMS_HOSP_2010on</td>
</tr>
<tr>
<td>INCLAIM (for DMMS)</td>
<td>DMMS_INCLM_to2012, and DMMS_INCLM_2013on</td>
</tr>
<tr>
<td>INDETAI (for DMMS)</td>
<td>DMMS_INDETAI_to2012, and DMMS_INDETAI_2013on</td>
</tr>
<tr>
<td>PSCLAIM1 (for DMMS)</td>
<td>DMMS_PS_to2012, and DMMS_PS_2013on</td>
</tr>
<tr>
<td>HOSP1 (for CMAS)</td>
<td>CMAS_HOSP_to2009</td>
</tr>
<tr>
<td>HOSP2 (for CMAS)</td>
<td>CMAS_HOSP_2010on</td>
</tr>
<tr>
<td>CMAS INCLAIM (for CMAS)</td>
<td>CMAS_INCLM_to2012, and CMAS_INCLM_2013on</td>
</tr>
<tr>
<td>INDETAI (for CMAS)</td>
<td>CMAS_INDETAI_to2012, and CMAS_INDETAI_2013on</td>
</tr>
<tr>
<td>PSCLAIM1 (for CMAS)</td>
<td>CMAS_PS_to2012, and CMAS_PS_2013on</td>
</tr>
<tr>
<td>ADEQUACY</td>
<td>CMAS_ADEQUACY</td>
</tr>
<tr>
<td>ADQFACS</td>
<td>CMAS_ADQFACS</td>
</tr>
<tr>
<td>WAV2UPDT</td>
<td>DMMS_WAV2UPDT</td>
</tr>
</tbody>
</table>
**FILE STRUCTURE CHANGES**

**CORE SAFs**

**RXHIST**

In prior years’ Treatment History Files RXHIST and RXHIST60, a death event is a single record with death date as BEGDATE and missing ENDDATE. In the 2015 SAF files, the single death event records were removed. A variable “DEATH” is added to RXHIST and RXHIST60. If DEATH=1, then the period’s end date equals death date.

**Example 1**: A patient (USRDS_ID=2135302) died on 3/21/2007. In prior years’ RXHIST (Table 4), there is one record with begdate=03/21/2007, enddate=., and rxgroup=death. This single death event is removed in the 2015 RXHIST SAF (Table 5).

**Example 2**: A patient (USRDS_ID=2135311) died on 10/24/2006. In prior years’ RXHIST (Table 4), there is one record with begdate=10/24/2006, enddate=., and rxgroup=death. This single death event is removed in the 2015 RXHIST SAF (Table 5).

**Table 4. Example of single death event included in prior years’ RXHIST**

<table>
<thead>
<tr>
<th>USRDS_ID</th>
<th>BEGDATE</th>
<th>ENDDATE</th>
<th>RXGROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2135302</td>
<td>08/21/2003</td>
<td>06/09/2004</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135302</td>
<td>06/10/2004</td>
<td>01/26/2007</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135302</td>
<td>01/27/2007</td>
<td>03/21/2007</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135302</td>
<td>03/21/2007</td>
<td>.</td>
<td>Death</td>
</tr>
<tr>
<td>2135311</td>
<td>08/22/2003</td>
<td>12/12/2004</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135311</td>
<td>12/13/2004</td>
<td>04/26/2005</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135311</td>
<td>04/27/2005</td>
<td>05/08/2005</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135311</td>
<td>05/09/2005</td>
<td>07/04/2005</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135311</td>
<td>07/05/2005</td>
<td>03/28/2006</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135311</td>
<td>03/29/2006</td>
<td>04/04/2006</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135311</td>
<td>04/05/2006</td>
<td>10/24/2006</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>2135311</td>
<td>10/24/2006</td>
<td>.</td>
<td>Death</td>
</tr>
</tbody>
</table>
Table 5. Example of single death event removed from 2015 RXHIST SAF and “death” variable added

<table>
<thead>
<tr>
<th>USRDS_ID</th>
<th>BEGDATE</th>
<th>ENDDATE</th>
<th>RXGROUP</th>
<th>DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2135302</td>
<td>08/21/2003</td>
<td>06/09/2004</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135302</td>
<td>06/10/2004</td>
<td>01/26/2007</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135302</td>
<td>01/27/2007</td>
<td>03/21/2007</td>
<td>Hemodialysis</td>
<td>1</td>
</tr>
<tr>
<td>2135311</td>
<td>08/22/2003</td>
<td>12/12/2004</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135311</td>
<td>12/13/2004</td>
<td>04/26/2005</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135311</td>
<td>04/27/2005</td>
<td>05/08/2005</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135311</td>
<td>05/09/2005</td>
<td>07/04/2005</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135311</td>
<td>07/05/2005</td>
<td>03/28/2006</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135311</td>
<td>03/29/2006</td>
<td>04/04/2006</td>
<td>Hemodialysis</td>
<td>0</td>
</tr>
<tr>
<td>2135311</td>
<td>04/05/2006</td>
<td>10/24/2006</td>
<td>Hemodialysis</td>
<td>1</td>
</tr>
</tbody>
</table>

Medical Evidence Form

In prior years’ Core SAF, there were three Medical Evidence Form data files: MEDEVID, MEDEVID95, and MEDEVID05. MEDEVID95 includes Medical Evidence data from the 1995 form; MEDEVID05 includes Medical Evidence data from the 2005 form; and MEDEVID includes data from both the MEDEVID95 and MEDEVID05 forms. In the 2015 Core SAF, only one Medical Evidence Form data file is created: MEDEVID, which includes Medical Evidence data from the 1987, 1995 and 2005 form versions.

ESRD INSTITUTIONAL CLAIMS

The ESRD Institutional Claims dataset files incorporate claims records with the claim through date (clm_thru) greater than or equal to the first service date. The data structure of the 2013 Institutional Claims Files is different from that in prior years. Details about prior years’ files are described in Section 5: Medicare Claims, ESRD Institutional Claims File Structure. Table 6 offers a comparison of the data structure for 2013 claims files with that of 2012 and prior claims files.

For the 2013 Institutional Claims data, three types of files were created for five types of institutional claims services. The three types of files are: claim-level file (CLM), multiple trailers for revenue center details (DET, previously REV), and multiple trailers for diagnosis and procedure details (DXP, previously DET) files. The five types of institutional claims services are: Outpatient (OP), Inpatients (IP), Home Health (HH), Hospice (HS), and SN (Skilled Nursing Facility). Therefore, instead of only three ESRD Claims files, the 2013 ESRD Claims SAFs include 15 different files (Table 6).
Table 6. Relationship of 2013 Institutional Claims dataset with 2012 and prior years’ claims dataset

<table>
<thead>
<tr>
<th>Institutional Claims dataset structure (2012 and prior files, yyyy is year)</th>
<th>Institutional Claims dataset structure (2013 files)</th>
</tr>
</thead>
<tbody>
<tr>
<td>incyyyy</td>
<td>clm_yyyy</td>
</tr>
<tr>
<td>where hcfasaf=&quot;H&quot; (home health)</td>
<td>hh_clm_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;S&quot; (hospice)</td>
<td>hs_clm_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;I&quot; (inpatient)</td>
<td>ip_clm_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;O&quot; (outpatient)</td>
<td>op_clm_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;D&quot; (dialysis)</td>
<td>claim_clinical</td>
</tr>
<tr>
<td>where hcfasaf=&quot;N&quot; (skilled nursing facility)</td>
<td>sn_clm_2013</td>
</tr>
<tr>
<td>detyyyyy</td>
<td>dxp_yyyy</td>
</tr>
<tr>
<td>where hcfasaf=&quot;H&quot; (home health)</td>
<td>hh_dxp_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;S&quot; (hospice)</td>
<td>hs_dxp_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;I&quot; (inpatient)</td>
<td>ip_dxp_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;O&quot; (outpatient)</td>
<td>op_dxp_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;N&quot; (skilled nursing facility)</td>
<td>sn_dxp_2013</td>
</tr>
<tr>
<td>revyyyy</td>
<td>det_yyyy</td>
</tr>
<tr>
<td>where hcfasaf=&quot;H&quot; (home health)</td>
<td>hh_dex_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;S&quot; (hospice)</td>
<td>hs_dex_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;I&quot; (inpatient)</td>
<td>ip_dex_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;O&quot; (outpatient)</td>
<td>op_dex_2013</td>
</tr>
<tr>
<td>where hcfasaf=&quot;N&quot; (skilled nursing facility)</td>
<td>sn_dex_2013</td>
</tr>
</tbody>
</table>

The file previously named incyyyy is now known as clm_yyyy. The dataset previously named detyyyyy is now known as dxp_yyyy. The dataset previously named revyyyy is now known as det_yyyy.

ESRD PHYSICIAN/SUPPLIER CLAIMS

The ESRD Physician/Supplier Files are built by keeping claims records in year 2013 Physician/Supplier (PS) and Durable Medical Equipment (DME) claims files with the claim through date (clm_thru) greater than or equal to the first service date. The file structures for Physician/Supplier claims prior to 2012, 2012 claims and in 2013 claims are different. The details are described in Section 5: Medicare Claims, ESRD Physician/Supplier Claims File Structure.

For the 2013 Physician/Supplier Claims, three types of files were created for PS claims and DME claims: claim-level file (CLM), multiple trailers for line item details of the claim (LINE), and multiple trailers for diagnoses and procedure details of the claim (DX). Therefore, instead of only one ESRD Claims File, the 2013 ESRD Physician/Supplier Claims SAFs include six different files (Table 7).
Table 7. Relationship of 2013 Physician/Supplier Claims datasets with 2012 and prior years’ claims datasets

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PS2012 where CLMTYP=&quot;P&quot; (physician/supplier) where CLMTYP=&quot;D&quot; (durable medical equipment)</td>
<td>ps_clm_2013, ps_line_2013 dme_clm_2013, dme_line_2013</td>
</tr>
<tr>
<td>N/A</td>
<td>New: ps_dx_2013 dme_dx_2013</td>
</tr>
</tbody>
</table>

**Pre-ESRD Institutional, Physician/Supplier, and Part D Claims**

The Pre-ESRD Files incorporate claims records prior to the first service date, i.e., with the claim through date (clm_thru) less than the first service date. The data structure of the 2015 SAF, Pre-ESRD Institutional and Physician/Supplier Claims, is the same as that of the ESRD Files, except that the patient cohorts are incident patients for an incident year in each file, and each file contains pre-ESRD records from four years of claims files prior to the incident year and pre-ESRD records in incident-year claims files, with a total of five years of pre-ESRD records (Table 8). File names ending with “inc2011” include pre-ESRD records for patients incident in 2011; file names ending with “inc2012” include pre-ESRD records for patients incident in 2012; file names ending with “inc2013” include pre-ESRD records for patients incident in 2013; file names starting with “preesrd5y” include five years of pre-ESRD records; and file names starting with “preesrd3y” include three years of pre-ESRD records.

Table 8. Pre-ESRD file names and descriptions

<table>
<thead>
<tr>
<th>File name</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Sy” in file name indicate there are 5 years of Pre-ESRD records “inc2011” in file name indicates patients in the file are patients incident in 2011</td>
<td></td>
</tr>
<tr>
<td>“Sy” in file name indicates there are 5 years of Pre-ESRD records “inc2012” in file name indicates patients in the file are patients incident in 2012</td>
<td></td>
</tr>
<tr>
<td>“Sy” in file name indicates there are 5 years of Pre-ESRD records “inc2013” in file name indicate patients in the file are patients incident in 2013</td>
<td></td>
</tr>
</tbody>
</table>

**Hospitalization SAFs**

Prior years’ HOSP1 and HOSP2 SAFs are combined and named HOSP_to2009. Prior years’ HOSP3 is renamed as HOSP_2010on.
VARIABLE CHANGES

Several additions, deletions, and modifications were made to variables in the following 2015 files.

PATIENTS SAF

Eleven variables have been added to the PATIENTS File:

- First Medicare Entitlement end date-Part A (FIRST_MCARE_PTA_END)
- First Medicare Enrollment reason code-Part A (FIRST_MCARE_PTA_REASON)
- First Medicare Entitlement start date-Part A (FIRST_MCARE_PTA_START)
- First Medicare Enrollment status –Part A (FIRST_MCARE_PTA_STATUS)
- First Medicare Entitlement end date-Part B (FIRST_MCARE_PTB_END)
- First Medicare Enrollment reason code-Part B (FIRST_MCARE_PTB_REASON)
- First Medicare Entitlement start date-Part B (FIRST_MCARE_PTB_START)
- First Medicare Enrollment status –Part B (FIRST_MCARE_PTB_STATUS)
- First Medicare Part D start date (FIRST_MCARE_PTD_START)
- First Service Date Source (FSD_SOURCE)
- Death Date Source (DEATH_SOURCE)

MEDEVID SAF

One variable PROVUSRD (USRDS Assigned Facility ID) is added to the Medical Evidence File MEDEVID.

ESRD, PRE-ESRD AND CKD PART D DATA

In ESRD and pre-ESRD Part D enrollment data, the variables indicating plan benefit package IDs (PTD_PBP_ID_01 – PTD_PBP_ID_12), and segment IDs (PTD_SGMT_ID_01 - PTD_SGMT_ID_12) have been added.

In ESRD and pre-ESRD Part D event data, the following variables have been added:

- Covered D Plan Paid Amount, or CPP (CVRD_D_PLAN_PD_AMT)
- Gross Drug Cost Above Out-of-Pocket Threshold, or GDCA (GDC_ABV_OOPT_AMT)
- Gross Drug Cost Below Out-of-Pocket Threshold or GDCB (GDC_BLW_OOPT_AMT)
- Low Income Cost Sharing Subsidy Amount, or LICS (LICS_AMT)
- Non-Covered Plan Paid Amount, or NPP (NCVRD_PLAN_PD_AMT)
- Other TrOOP Amount (OTHR_TROOP_AMT)
- Formulary ID, the first Column of Composite Foreign Key to Formulary File (FORMULARY_ID)
- Formulary Rx ID, the second Column of Composite Foreign Key to Formulary File (FRMLRY_RX_ID) have been added.
For CKD Part D Event File, besides the variables listed above (except FORMULARY_ID and FRMLRY_RX_ID, which exist in the 2012 file), Plan contract record ID (PLAN_CONTRACT_REC_ID) has also been added.

**Institutional Claims SAF**

Table 9 lists the variables that were added to the Institutional Claims Files.

**Table 9. New variables in 2015 Institutional Claims SAF**

<table>
<thead>
<tr>
<th>Variable name</th>
<th>Variable label</th>
<th>Type of file</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE_OF_BILL</td>
<td>Claim facility/service type</td>
<td>CLM, DXP, DET</td>
</tr>
<tr>
<td>PTNRESP</td>
<td>PAYMENT PATIENT RESPONSIBLE FOR</td>
<td>CLM</td>
</tr>
<tr>
<td>RBENPMT</td>
<td>Revenue Center Beneficiary Payment Amount</td>
<td>CLM</td>
</tr>
<tr>
<td>RPMT</td>
<td>MEDICARE PAYMENT AMOUNT</td>
<td>CLM</td>
</tr>
<tr>
<td>PDGNS_CD</td>
<td>Primary diagnosis code</td>
<td>DXP</td>
</tr>
<tr>
<td>Prpayamt</td>
<td>Amount paid by primary payer</td>
<td>DXP</td>
</tr>
<tr>
<td>PTNRESP</td>
<td>PAYMENT PATIENT RESPONSIBLE FOR</td>
<td>DET</td>
</tr>
<tr>
<td>RBENPMT</td>
<td>Revenue Center Beneficiary Payment Amount</td>
<td>DET</td>
</tr>
<tr>
<td>RPMT</td>
<td>MEDICARE PAYMENT AMOUNT</td>
<td>DET</td>
</tr>
<tr>
<td>PRCRCD01-PRCDRCD25</td>
<td>Claim Procedure Code</td>
<td>CLM</td>
</tr>
<tr>
<td>PVRSNCD01-PVRSNCD25</td>
<td>Procedure code version (ICD9/10)</td>
<td>CLM</td>
</tr>
<tr>
<td>HSPCSTRT</td>
<td>Hospice Admit Date</td>
<td>CLM</td>
</tr>
<tr>
<td>TDEDAMT</td>
<td>NCH Inpatient Total Deductible Amount</td>
<td>CLM</td>
</tr>
<tr>
<td>OCRRCN_DT</td>
<td>Claim Related Occurrence Date</td>
<td>DXP</td>
</tr>
<tr>
<td>OCRRCNCD</td>
<td>Claim Related Occurrence Code</td>
<td>DXP</td>
</tr>
<tr>
<td>POA_FLAG</td>
<td>Diagnosis was present at the time of admission (Y/N)</td>
<td>DXP</td>
</tr>
</tbody>
</table>
Table 10 lists the variables that were added to Physician/Supplier Claims Files.

**Table 10. New variables in 2015 Physician/Supplier Claims SAF**

<table>
<thead>
<tr>
<th>Variable name</th>
<th>Variable label</th>
<th>Type of file</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM_PMT_AMT</td>
<td>Amount paid by Medicare</td>
<td>CLM</td>
</tr>
<tr>
<td>CARR_CLM_BENE_PD_AMT</td>
<td>Amount paid by beneficiary for services</td>
<td>CLM</td>
</tr>
<tr>
<td>CARR_CLM_CASH_DDCTBL_APPLY_AMT</td>
<td>Cash deductible amount</td>
<td>CLM</td>
</tr>
<tr>
<td>CARR_CLM_PRMRY_PYR_PD_AMT</td>
<td>Amount paid by primary payer (not Medicare)</td>
<td>CLM</td>
</tr>
<tr>
<td>NCH_CARR_ALOW_CHRG_AMT</td>
<td>Allowed charge amount</td>
<td>CLM</td>
</tr>
<tr>
<td>NCH_CARR_SBMT_CHRG_AMT</td>
<td>Submitted charge amount</td>
<td>CLM</td>
</tr>
<tr>
<td>NCH_CLM_BENE_PMT_AMT</td>
<td>Total payment to beneficiary</td>
<td>CLM</td>
</tr>
<tr>
<td>NCH_CLM_PRVDR_PMT_AMT</td>
<td>Total payments to the provider</td>
<td>CLM</td>
</tr>
<tr>
<td>NCH_CLM_TYPE_CD</td>
<td>NCH Claim Type Code</td>
<td>CLM</td>
</tr>
<tr>
<td>LINE_BENE_PMT_AMT</td>
<td>Payment to beneficiary</td>
<td>LINE</td>
</tr>
<tr>
<td>LINE_BENE_PRMRY_PYR_PD_AMT</td>
<td>Amount paid by primary payer (non-Medicare)</td>
<td>LINE</td>
</tr>
<tr>
<td>LINE_NCH_PMT_AMT</td>
<td>Amount paid by Medicare</td>
<td>LINE</td>
</tr>
<tr>
<td>LINE_PRMRY_PYR_ALOW_CHRG_AMT</td>
<td>Primary payer allowed charge amount</td>
<td>LINE</td>
</tr>
<tr>
<td>NCH_CLM_TYPE_CD</td>
<td>NCH Claim Type Code</td>
<td>DX</td>
</tr>
<tr>
<td>CLM_DGNS_CD</td>
<td>Diagnostic code</td>
<td>DX</td>
</tr>
<tr>
<td>NCH_CLM_TYPE_CD</td>
<td>NCH Claim Type Code</td>
<td>DX</td>
</tr>
</tbody>
</table>

**FORMAT AND LABEL CHANGES**

**MODIFIED FORMATS**

The existing formats ACREJEPI, COUNTRY, $CODFMT, C_GRF_FU, DIA_MNT, $DISCREA, $DRG_Des, $ETHFMT, $FSCERT, $HCFAREG, IMMOR, KPTXTYP, PLACESV, PRV_PREG, RANGE, $RERED, $STATE, $STATFIP, $STERMCOD, $TOFIPSS and $URRFMT have been modified, details are in the What’s New in 2015 text file included with the Core SAF.

**NEW FORMATS**

Formats ACCTP, ADMID, AGE2oCAT, AGE6CAT, $CSTSHR, $CTBLCVR, $DEATHSOURCE, $DUALCODE, $ENRREA, $ENTSTAT, $ENSTATB, $ENTREB, $FSDSOURCE, $PTDCNT, and $RDSCODE were added to the 2015 SAF format catalog; details are in the What’s New in 2015 text file included with the Core SAF.

**REMOVED FORMATS**

The format $HCPCs, which is the description of the Healthcare Common Procedure Coding System (HCPCS), was removed from the format library. This format includes HCPCS Level I and Level II codes. HCPCS Level I codes use the AMA’s CPT® codes and describe services and procedures that
Physicians usually provide. HCPCS Level II codes describe services and procedures that are not provided by physicians.

HCPCS Level I codes are five digits and can have modifiers just like CPT codes. However, unlike CPT codes, HCPCS Level II codes are alphanumeric. They start with a letter and followed by four numbers. HCPCS modifiers are two characters and can be either two letters or a letter and a number.


Level II alphanumeric HCPCS procedure and modifier codes, with long and short descriptions can be found at: https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

Modified Label

The label for “TXFER_DT” in both TXFUUNOS_KI and TXFUUNOS_KP data was changed: “Stop Collect from 6/30/2004” has been removed from the label.

Methodology Changes

Facility Crosswalk File

The Facility Crosswalk File (xref_prv_2015.sas7bdat) provides:

- A linkage between PROVHCFA (HCFA assigned facility ID) and PROVUSRD (USRDS assigned facility ID)
- A linkage between PROVHCFA (HCFA assigned facility ID) and CTR_CD (UNOS Transplant Center Code)

Starting with the 2014 SAFs with 2012 Medicare Claims Files, the Facility Crosswalk includes all CMS facilities. Previously, it was limited to dialysis and transplant facilities based on the ESRD Facility Survey (CMS-2744). At present, PROVUSRD below 20000 are reserved for PROVHCFA from the ESRD Facility Survey (CMS 2744).

Starting from the 2015 SAFs, the Facility Crosswalk maintains a 1:1 relationship between PROVHCFA and PROVUSRD. Previously, multiple provider numbers can be mapped to the same PROVUSRD.
CROSSWALK OF THE FACILITY CROSSWALK FILE

The crosswalk of the Facility Crosswalk File (xref_prior_current_prv_2015.sas7bdat) is designed to convert the wrong PROVUSRD caused by the PROVUSRD assignment errors in previous Facility Crosswalks to the correct PROVUSRD in other data.

There are two types of PROVUSRD assignment errors:

1. Errors associated with one-to-many assignments prior to 2002. Besides PROVHCFA, FACILITY files prior to 2002 contain another provider number, MMACS labeled as the Medicare/Medicaid Automated Certification System. MMACS is considered related to PROVHCFA. Therefore, in FACILITY SAFs and crosswalks, a same PROVUSRD is assigned to both PROVHCFA and MMACS. However, such one-to-many assignments are discontinued from 2002 and on.

2. Systematic errors with the first assignment in 2005.

Although Facility Crosswalks starting from 2015 eliminated those problems, other data that use previous Facility Crosswalks as a data source carried over those problems. The crosswalk of the Facility Crosswalk is used to map the erroneous PROVUSRD by year existing in other data to the corrected PROVUSRD in the Facility Crosswalk File.

TX1FAIL IN PATIENTS AND FAILDATE IN TX

In prior years’ PATIENTS and TX Files, the following rule was applied to the transplant failure date:

For transplant patients, if transplant failure date is missing and patient died, transplant failure date is assigned to patient’s death date.

This rule was removed in the 2015 SAF PATIENTS File (variable TX1FAIL), and TX File (variable FAILDATE).

RECOVER RENAL FUNCTION MODALITY IN RXHIST

In prior years’ Treatment History Files RXHIST and RXHIST60, the following rule for defining recovered renal function was applied:

The recovered renal function (RRF) modality/event can be established only if it occurs within the first 180 days of first service date, and the RRF period persists for at least 90 days.

In the 2015 SAFs, RXHIST and RXHIST60, this rule was removed and all recovered renal function events were kept. Figure 1 shows the data sources and processing steps for USRDS SAFs.
Table 11 shows the year-to-year comparison of number of records in USRDS SAFs 2006-2015.

Table 11. Year-to-year comparison of number of records in USRDS Standard Analysis Files (SAFs)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENTS</td>
<td>1,698,706</td>
<td>1,801,298</td>
<td>1,910,161</td>
<td>2,024,425</td>
<td>2,138,876</td>
<td>2,260,986</td>
<td>2,377,166</td>
<td>2,497,498</td>
<td>2,709,247</td>
<td>2,830,454</td>
</tr>
<tr>
<td>MEVID†</td>
<td>1,164,686</td>
<td>1,147,657</td>
<td>1,265,566</td>
<td>1,385,589</td>
<td>1,505,285</td>
<td>1,630,270</td>
<td>1,753,496</td>
<td>1,862,922</td>
<td>2,105,748</td>
<td>2,812,913</td>
</tr>
<tr>
<td>RXHIST*</td>
<td>11,658,208</td>
<td>12,533,612</td>
<td>13,532,743</td>
<td>11,626,297</td>
<td>11,741,390</td>
<td>12,392,072</td>
<td>13,038,727</td>
<td>13,696,997</td>
<td>13,003,645</td>
<td>11,946,796</td>
</tr>
<tr>
<td>FACILITY</td>
<td>64,870</td>
<td>69,764</td>
<td>74,831</td>
<td>80,071</td>
<td>85,572</td>
<td>91,332</td>
<td>97,201</td>
<td>103,210</td>
<td>115,973</td>
<td>122,730</td>
</tr>
<tr>
<td>TX</td>
<td>289,533</td>
<td>308,002</td>
<td>324,476</td>
<td>343,051</td>
<td>360,297</td>
<td>378,536</td>
<td>395,347</td>
<td>413,493</td>
<td>451,499</td>
<td>471,755</td>
</tr>
<tr>
<td>TXWAIT*</td>
<td>378,262</td>
<td>405,165</td>
<td>437,256</td>
<td>474,348</td>
<td>513,028</td>
<td>546,239</td>
<td>579,225</td>
<td>618,511</td>
<td>690,217</td>
<td>723,824</td>
</tr>
</tbody>
</table>

*MEVID is the total number of observations between Medevi95 and Medevi05 prior to 2014.

†TXWAIT is the total number of observations between Waitlist_ki and Waitlist_kp.

‡RXHIST single death events are removed from 2015 file

Getting Started

Work on a typical study consists of determining the study cohort (patients), study variables, selecting the variables from the datasets in which they are stored, merging the selected variables into one or more datasets for analysis, and finally, performing the statistical analyses of the data. This section offers dataset examples of this process to first-time users of the USRDS SAFs.
Determining the study cohort is particularly critical when performing analysis of Medicare Claims data. Medicare claims data provides a complete picture only for those patients for whom Medicare is the primary payer. For patients with other insurers or Medicare as secondary payer, information will not be captured for hospitalizations or other treatment paid for by alternate insurance. For this reason, inclusion of Medicare claims for patients with other insurers or Medicare as secondary payer may lead to inaccurate results. In order to do an analysis restricted to Medicare primary payer patients, the Payer History File should be used to identify claims falling into Medicare primary payer periods. We suggest using the syntax in “SAS Example 9: Create a Patient Cohort of 2008 Medicare Primary Incident Patients” as a guide; the example relies on the Payer History File (see Section 4: Payer History).

All USRDS data are stored in SAS datasets that were created in the Windows environment and can be used only on the Windows operating system. Using the datasets on another computer platform requires moving and converting the data to SAS datasets for that platform. Using another data analysis system also requires a conversion to a format compatible with that system.

We provide examples using basic SAS code. New SAS users should take classes, consult colleagues, or otherwise become familiar with the SAS system. Regardless of SAS experience, all users must know the following:

- The location of the SAS dataset
- The location of the SAS catalog of FORMATS

In the examples, the datasets and the FORMAT catalog are assumed to be in the same directory, namely, C:\SAF. Two SAS statements are needed to point to this information:

LIBNAME saf "c:\saf"; * Directory location of the data;
LIBNAME LIBRARY "c:\saf"; * Directory location of format catalog;

Always assume that these two statements are required in all code. (See Appendix C: Data Formatting for additional information.) The datasets and the format catalog may be in different directories.

**Basic SAS Use**

The SAS CONTENTS procedure generates a list of all variables in the dataset and a label associated with each. The information in this label is usually an adequate indication of whether the variable will be in use; however, PROC CONTENTS is always the best method for obtaining the latest variable list, as last minute updates may not be reflected in the printed documentation (see Appendix B: Data File Descriptions).
Note: In the following program examples, SAS commands, keywords, and procedures are in uppercase text. Datasets, comments, and variables in which SAS will perform operations, are in lowercase text.

To determine the contents of the PATIENTS dataset, or any dataset, use the following code (remember the two LIBNAME requirement).

```sas
PROC CONTENTS DATA=saf.patients;
   TITLE1 'DATASET: saf.patients';
RUN;
```

To see what the data look like, use the SAS procedure PRINT to list all observations of the dataset:

```sas
PROC PRINT data=saf.patients;
   TITLE1 'DATASET: saf.patients';
RUN;
```

A dataset can have millions of observations. To print the first 500, use the following code:

```sas
PROC PRINT DATA=saf.patients (OBS=500);
   TITLE1 'DATASET: saf.patients';
RUN;
```

To print a group of observations other than the first N observations, use the following code; this example prints observations 1,500–2,000, inclusive:

```sas
PROC PRINT DATA=saf.patients (FIRSTOBS=1500 OBS=2000);
   TITLE1 'DATASET: saf.patients';
RUN;
```

A dataset can contain hundreds of variables. Print selected variables using the VAR statement:

```sas
PROC PRINT DATA=saf.patients (OBS=500);
   VAR usrds_id sex race incyear;
   TITLE1 'DATASET: saf.patients';
RUN;
```

There are two parts to the “DATA=” expression. The first is the directory location, defined by the LIBNAME, and the second is the dataset name. The first part (directory location) implies that the dataset is permanent. Later examples do not include this part, and the datasets you create will disappear when you leave SAS. To permanently save a dataset, the first part of the expression must be included.

**SAS Formats for USRDS Data**

Information in a dataset may be coded. Thus, the variable GENDER may have the values F, M, or U, where “F” is the coded value for female, “M” is the value for male, and “U” is the value for unknown. Using one character instead of several saves disk storage, but because the coded values are not always
easy for users to understand, a format is assigned to translate them. Many variables have been assigned formats by the USRDS.

In each program, SAS must be told where these formats are. Assume that the format catalog is in the directory C:\SAF, then the following SAS LIBNAME makes the formats accessible to your SAS programs:

```
LIBNAME LIBRARY “c:\saF”; * Directory location of format catalog;
```

The SAS keyword LIBRARY must be used because it tells SAS to look for formats in the directory, C:\SAF. Other methods can accomplish this, but not as easily. To bypass the use of formats, use the following two SAS statements before running any SAS procedures:

```
LIBNAME LIBRARY;
OPTIONS NOFMTERR;
```

Bypassing the use of formats allows you to see raw data instead of the formatted values, which may be useful when you need to write SAS IF statements to control the flow of your program in a SAS data step. (See Appendix C: Data Formatting for a tabular list of the formats with their coded values.)

**Comment Lines**

Comment lines in the SAS code look like this:

```
/* Comment line */
* Comment line;
```

These refer to any descriptive comment. The use of comments is optional, but is strongly recommended.

**The SAF Directory**

Throughout this section, SAF is used as the permanent SAS LIBNAME. It is assumed that all of the USRDS SAF datasets and catalogs have been placed in this directory. If the datasets have been placed in the WINDOWS directory C:\SAF, then the following SAS LIBNAME would point to the SAF datasets:

```
LIBNAME saf “c:\saF”;
```

Note: The datasets may be loaded into any directory, with the directory in the LIBNAME changed accordingly.
SAS Examples

Example 1: Patient Cohort Included in USRDS Annual Data Report (ADR)

*-- Patients are flagged with adrind=0 due to inconsistent dates or incomplete identifiers including patients with first service date and death date on same day, or no first service date. --*;

DATA adr_patients non_adr_patients;
  SET saf.patients;
  IF adrind=1 THEN OUTPUT adr_patients;/*adrind=1,ADR patient*/
  ELSE OUTPUT non_adr_patients;/*adrind=0, non-ADR patient*/
RUN;

Example 2: Incident Cohort

*-- Create a patient cohort of incident patients from 2000 to 2010 --*;

DATA inc2000_2010 (KEEP=usrds_id first_se incyear first_modality);
  SET saf.patients;
  IF 2000<=incyear<=2010 AND adrind=1; /*only pull ADR patients*/
RUN;

PROC FREQ DATA=inc2000_2010;
  TABLE incyear;
  TITLE 'Frequency Distribution of Incident Patients 2000 - 2010 by Incident Year';
RUN;

PROC FREQ DATA=inc2000_2010;
  TABLE incyear * first_modality;
  TITLE 'Frequency Distribution of Incident Patients 2000 - 2010 by Incident Year and Modality';
RUN;
**Example 3: Incident Patient Distribution by Demographic Data**

PROC FREQ DATA=saf.patients;
   TABLE incagec sex race disgrpc;
   WHERE (incyear = 2010 AND adrind=1);
   TITLE 'Frequency Distribution of 2010 Incident Patients by Demographic Data';
RUN;

**Example 4: Point Prevalent Cohort**

*-- Create a patient cohort of point prevalent dialysis patients who were alive on January 1, 2010. --*

DATA pre_2010 (KEEP=usrds_id rxgroup);
   SET saf.rxhist60;
   BY usrds_id begdate;
   IF (begdate <= MDY(1,1,2010)) AND
      ((enddate >= MDY(1,1,2010) and death ne 1)) AND
      (rxgroup NOT IN ("B","X","Z","T")) THEN
      OUTPUT;
RUN;

PROC FREQ DATA=pre_2010;
   TABLE rxgroup;
   TITLE 'Frequency Distribution of 1-1-2010 Point Prevalent Patients by Modality';
RUN;

**Example 5: 2005 Incident Patient Survival Rates (Kaplan-Meier)**

*-- Calculate survival rates of 2005 incident dialysis patients using Kaplan-Meier method, censoring at transplant. --*

DATA inc_2005_s;
   SET saf.patients (where=((incyear = 2005) AND (first_modality ^= "T") AND adrind=1))
   KEEP=usrds_id adrind first_se incyear first_modality died tx1date);
   BY usrds_id;
* Calculate the survival time (in months) of each incident patient with 12/31/2010 as maximum censoring date.;
   t = (MIN(died, tx1date, MDY(12,31,2010)) - first_se + 1) / 30.4375;
   IF (t < 0) THEN t = 0;
* Determine whether the patient is censored. 12/31/2010 is used as start date of censoring.;
   c = (MIN(died, tx1date, MDY(12,31,2010)) = died) AND (MIN(died, tx1date, MDY(12,31,2010)) <> tx1date);
RUN;

PROC LIFETEST DATA=inc_2005_s METHOD=KM NOTABLE PLOTS=(s) OUTSURV=surv2005 CONFTYPE=LINEAR lineprinter;
   TIME t*c(0);
   TITLE '2005 Incident Dialysis Patients Survival Rates';
RUN;
Example 6: Merge With Medical Evidence File (CMS 2728)

*-- Demonstrate a way to extract comorbid conditions for a pre-defined study cohort from the Medical Evidence File. --*;
DATA inc2008_me;
   MERGE saf.patients (IN=x1 WHERE=(incyear=2008 AND adrind=1)
      KEEP=usrds_id adrind first_se incyear first_modality)
   saf.medevid (IN=x2
      KEEP=usrds_id cancer cararr carfail cva diabins diabprim dysrhyt
      hyper ihd mi pulmon pvasc como_canc);
   BY usrds_id;
   IF x1 AND x2;
   IF (FIRST.usrds_id);
RUN;

Example 7: 2008 Incident Patient Survival Rates (Kaplan-Meier)

*-- Show a survival rate calculation stratified by patient comorbid condition, not censored at transplant. --*;
DATA inc2008_me;
   MERGE saf.patients (IN=x1 WHERE=(incyear=2008 AND adrind=1) KEEP=usrds_id adrind first_se incyear
      first_modality)
   saf.medevid (IN=x2 KEEP=usrds_id cancer cararr carfail cva diabins diabprim dysrhyt
      hyper ihd mi pulmon pvasc como_canc);
   BY usrds_id;
   IF x1 AND x2;
   IF (FIRST.usrds_id);
RUN;

DATA inc_2008_s;
   SET inc2008_me;
   BY usrds_id;
   IF (UPCASE(cancer) IN ("1" "2" "Y" "N") or UPCASE(como_canc) IN ("1" "2" "Y" "N") );
   IF (UPCASE(cancer) IN ("1" "Y") or UPCASE(como_canc) IN ("1" "Y");
      THEN can = 1;
   ELSE can = 0;

   * Calculate the survival time (in months) of each incident patient.;
   t = (MIN(died, MDY(12,31,2010)) - first_se + 1) / 30.4375;
   IF (t < 0) THEN t = 0;
   * Determine whether the patient is censored.
   c = (MIN(died, MDY(12,31,2010)) = died);
RUN;
PROC LIFETEST DATA=inc_2008_s METHOD=KM NOTABLE PLOTS=(s) OUTSURV=surv2008 CONFTYPE=LINEAR lineprinter;
   TIME t*c(0);
   STRATA can;
   TITLE '2008 Incident ESRD Patients Survival Rates by Co-Morbidity';
RUN;
Example 8: Waiting List Access Rate

/*-- Determine waiting list access rate to December 31, 2010, of 2008 incident dialysis patients who were registered in the transplant waiting list. --*/
DATA txwait;
   SET saf.waitseq_ki saf.waitseq_kp;
RUN;
PROC SORT data=txwait;
   By usrds_id;
RUN;

DATA inc2008_me;
   MERGE saf.patients (IN=x1 WHERE=(incyear=2008 AND adrind=1) KEEP=usrds_id adrind first_se incyear first_modality)
       saf.medevide (IN=x2 KEEP=usrds_id cancer cararr carfail cva diabins diabprim dysrhyt hyper ihd mi pulmon pvas como_canc);
   BY usrds_id;
   IF x1 AND x2;
   IF (FIRST.usrds_id);
RUN;

DATA inc_2008_w;
   MERGE inc2008_me (IN=x1) txwait (IN=x2 KEEP=usrds_id begin);
   BY usrds_id;
   IF x1;
   * Extract only 2008 incident dialysis patients.;
   IF (first_modality ^= "T");
   * Make sure all dialysis patients who were not put on the waiting list;
   * are censored at the end of follow-up period.;
   IF x1 AND ^x2 THEN begin = MDY(1,1,2011);
   * Calculate the waiting list access time (in month) of each incident patient.;
   t = (MIN(begin, died, MDY(12,31,2010)) - first_se + 1) / 30.4375;
   IF (t < 0) THEN t = 0;
   * Determine whether the patient is censored.;
   c = (MIN(begin, died, MDY(12,31,2010)) = begin);
RUN;
PROC LIFETEST DATA=inc_2008_w METHOD=KM NOTABLE PLOTS=(s) OUTSURV=wait2008 CONFTYPE=LINEAR lineprinter;
   TIME t*c(0);
   TITLE '2008 Incident Dialysis Patients Waiting List Access Rates';
RUN;
Example 9: Create a Patient Cohort of 2008 Medicare Primary Incident Patients

*-- Combine payer information with original incident cohort and limit to patients with Medicare primary payers at first service date. --*;
DATA medicare_inc_2008;
    MERGE saf.patients (IN=x1 WHERE=(incyear=2008 AND adrind=1))
        saf.payhist(IN=x2 KEEP=usrds_id mcare payer dualelig begdate enddate);
    BY usrds_id;
    IF x1 AND (payer="MPAB" OR payer="MPO") AND begdate <= first_se
        AND enddate>=first_se;
RUN;

Example 10: Total Admission Rate

*-- Link patients file with hospitalization file; gather hospitalizations within period of interest (includes only patients with hospitalizations). --*;
DATA hospdat;
    MERGE saf.patients (in=x WHERE=(incyear=2012 AND adrind=1))
        saf.inc2012 (in=y KEEP=usrds_id clm_from clm_thru);
    BY usrds_id;
    IF x AND y;
        sfu = first_se + 91;
        efu = MIN(died, first_se + 455);
        IF (died NE .) AND (died < sfu) THEN DELETE;
        IF ((sfu>clm_thru) OR (efu<clm_from)) THEN DELETE;
    FORMAT sfu efu MMDDYY10. ;
RUN;

PROC SORT DATA=hospdat;
    BY usrds_id clm_from clm_thru;
RUN;

DATA rate;
    SET hospdat;
    BY usrds_id;
    RETAIN n_hos n_adm exptime rt_adm;
    IF FIRST.usrds_id THEN
        DO; /* INITIALIZE RETAIN VARIABLES FOR EACH USRDS_ID */
            n_hos=0;
            n_adm=0;
            exptime=0;
            rt_adm=0;
        END;
    * FOR HOSPITALIZATIONS OVERLAPPING STUDY START ONLY COUNT;
    * HOSPITAL DAYS, NOT AS ADMISSION;
IF (clm_from<sfu<=clm_thru) THEN n_hos=n_hos+(MIN(clm_thru,efu)-sfu+1);
* IF WITHIN STUDY PERIOD COUNT DAYS (UP TO STUDY END) AND;
* ADMISSIONS;
ELSE IF (sfu<=clm_from<=efu) THEN
DO;
   n_hos=n_hos+(MIN(clm_thru,efu)-clm_from +1);
   n_adm=n_adm+1;
END;
IF LAST.usrds_id THEN /* Output one record per USRDS_ID */
DO;
   exptime=(efu-sfu-n_hos+1)/365;
   IF exptime>0 then rt_adm=n_adm*1000/exptime;
   ELSE IF (exptime<0) THEN exptime=0;
   OUTPUT;
END;
RUN;

DATA rateall;
MERGE saf.patients (IN=x1 WHERE=(incyear=2012 AND adrind=1)) rate (IN=x2);
BY usrds_id;
sfu = first_se + 91;
efu = MIN(died, first_se+455);
IF (died NE .) AND (died < sfu) THEN DELETE;
FORMAT sfu efu MMDDYY10.;
IF x2=0 THEN
DO;
   n_hos=0;
   n_adm=0;
   rt_adm=0;
   exptime=(efu-sfu+1)/365;
END;
IF x1 THEN OUTPUT;
RUN;

/*-- Calculate mean admissions per 1,000 patient-years by sex. --*/;

PROC TABULATE DATA=rateall;
   VAR rt_adm;
   CLASS sex;
   WEIGHT exptime;
   TABLE sex=""*rt_adm=""*mean*f=8.1;
   KEYLABEL mean="";
   TITLE1 'Total Admission rates per 1,000 patient years by sex';
RUN;
**Example 11: First Admission Rate**

*-- Link patients file with hospitalization file; gather hospitalizations within period of interest (includes only patients with hospitalizations). --*

```
DATA hospdat;
    MERGE saf.patients (in=x WHERE=(incyear=2012 AND adrind=1))
        hosp.inc2012 (in=y KEEP=usrds_id clm_from clm_thru);
    BY usrds_id;
    IF x AND y;
    sfu = first_se + 91;
    efu = MIN(died, first_se+455);
    IF (died NE .) AND (died < sfu) THEN DELETE;
    IF ((sfu>clm_thru) or (efu<clm_from)) then delete;
    FORMAT sfu efu MMDDYY10.;
RUN;
```

```
DATA frate;
    SET hospdat;
    BY usrds_id;
    RETAIN n_adm exptime rt_adm flag;
    IF FIRST.usrds_id THEN
        DO; /* INITIALIZE RETAIN VARIABLES FOR EACH USRDS_ID */
        n_adm=0;
        exptime=0;
        rt_adm=0;
        flag=0;
        END;
    * FOR HOSPITALIZATIONS OVERLAPPING STUDY START SET EXPOSURE;
    * TIME TO ZERO TO EXCLUDE FROM RATE;
    IF (clm_from<sfu<=clm_thru) THEN
        DO;
        exptime=0;
        flag=1;
        END;
    * IF WITHIN STUDY PERIOD COUNT ADMISSION AND CALCULATE;
    * TIME TO ZERO TO EXCLUDE FROM RATE;
    ELSE IF (sfu<=clm_from<=efu) AND flag=0 THEN
        DO;
        exptime=(clm_from-sfu+1)/365;
        n_adm=n_adm+1;
        flag=1;
        END;
    IF LAST.usrds_id THEN /* OUTPUT ONE RECORD PER USRDS_ID */
        DO;
```
IF exptime>0 THEN rt_fadm=n_adm*1000/exptime;
OUTPUT;
END;
RUN;

/*-- Combine result with original incident sample to include patients without hospitalizations. --*/;

DATA frateall;
MERGE saf.patients (IN=x1 WHERE=(incyear=2012 AND adrind=1)) frate (IN=x2);
BY usrds_id;
sfu = first_se + 91;
efu = MIN(died, first_se+455);
IF (died NE .) AND (died < sfu) THEN DELETE;
FORMAT sfu efu MMDDYY10.;
IF x2=0 THEN
DO;
   n_adm=0;
   rt_fadm=0;
   exptime=(efu-sfu+1)/365;
END;
IF x1 THEN OUTPUT;
RUN;

PROC TABULATE DATA=frateall;
   VAR rt_fadm;
   CLASS sex;
   WEIGHT exptime;
   TABLE sex=""*rt_fadm=""*mean*f=8.1;
   KEYLABEL mean="";
   TITLE1 'First Admission rates per 1,000 patient years';
RUN;
Example 12: Total Cost and Cost by Service Type

/*total ESRD Medicare cost for institutional claims 2012*/
PROC SQL;
    CREATE TABLE total_in_cost AS
    SELECT SUM(clm_amt) AS cost
    FROM saf.inc2012;
QUIT;

/*total ESRD Physician/Supplier cost in 2012 claims file*/
PROC SQL;
    CREATE TABLE total_ps_cost AS
    SELECT SUM(pmtamt) AS cost
    FROM saf.ps2012;
QUIT;

/*total ESRD Medicare cost for institutional claims 2012, applied to 2012 and prior years’ claims SAFs. Records for different type of services are in separate files in 2013 claim SAF*/
PROC SQL;
    CREATE TABLE in_cost_bytype AS
    SELECT hcfasaf,
           SUM(clm_amt) AS cost
    FROM saf.inc2012
    GROUP BY hcfasaf;
QUIT;

/*total ESRD Physician/Supplier cost in 2012 claims file, applied to 2012 and prior years’ claims SAFs. Records for different types of services are in separate files in 2013 claims SAF, and pmtamt variable is in line file*/
PROC SQL;
    CREATE TABLE total_ps_cost AS
    SELECT hcfasaf,
           SUM(pmtamt) AS cost
    FROM saf.ps2012
    GROUP BY hcfasaf;
QUIT;
Methods & Databases

Section 1: ESRD Data and the USRDS ESRD Database

The main objective of the USRDS Coordinating Center is to use all relevant ESRD data to create an integrated and consistent database system for outcomes research. The USRDS ESRD database includes ESRD patient demographic and diagnosis data, biochemical values, dialysis claims, and information on treatment history, hospitalization events, and physician/supplier services.

Data Sources

The data used by the USRDS Coordinating Center originates from the Centers for Medicare & Medicaid Services (CMS), the Organ Procurement and Transplantation Network (OPTN), the Centers for Disease Control (CDC), the ESRD Networks, the USRDS Special Studies, and the U.S. Census.

Consolidated Renal Operations in a Web-enabled Network (CROWN)

The major source of ESRD patient information for the USRDS is currently the CMS Consolidated Renal Operations in a Web-enabled Network (CROWN) data system. This database contains demographic, diagnostic, and treatment history information for all Medicare beneficiaries with ESRD. Data for non-Medicare patients have also been included since 1995, when ESRD Medical Evidence Report forms (CMS 2728) became mandatory for all ESRD patients.

The original CMS ESRD database was called the Program Management and Medical Information System (PMMIS); this was replaced by the Renal Beneficiary and Utilization System (REBUS) in 1995. Having advanced its database technology, CMS migrated the REBUS database into an Oracle relational database system called the Renal Management Information System (REMIS) in the fall of 2003.

In 2003, the Standard Information Management System (SIMS) database of the ESRD Networks was also established; SIMS included information to track patient movement in and out of ESRD facilities, and their transitions from one treatment modality to another. The REMIS database originally included all patients who were alive and had ESRD as of January 1, 1995, or were incident after this date, an approach adopted from the procedure used to create the SIMS database. However, because the REMIS system as it existed did not include legacy patients for longitudinal studies, CMS expanded it in the fall of 2004 to include all ESRD patients. Together, REMIS and SIMS comprised the CROWN system.

In May 2012, Internet-based access to the data system, CROWNWeb, was rolled out nationally. It replaced the functionality of SIMS, interfaces with REMIS, and also provides new data to support calculation of clinical measures.
CMS regularly updates the REMIS/CROWNWeb database, using the Medicare Enrollment Database (EDB), Medicare inpatient and outpatient claims, the OPTN transplant database, ESRD Medical Evidence Report forms (CMS 2728), and ESRD Death Notification forms (CMS 2746). CMS has established data integrity rules to ensure accurate identification of patients in the CMS databases. Each ESRD patient (new or existing) is identified with a unique patient identification number common to both databases, guaranteeing that data for all patients are consistently managed over time.

Working solely with data from the Medical Evidence Report, the USRDS Coordinating Center worked to establish the first ESRD service data for these patients, but could not consistently generate a detailed treatment history. The integration of the CROWNWeb event data into the ESRD database, however, allows for the examination of issues that arise in the non-Medicare ESRD population, such as the large and growing number of lost-to-follow-up patients, and for gathering data on patients for whom no data were previously available on initial modality or death.

**CMS ESRD Medical Evidence Report Form (CMS 2728)**

The CMS ESRD Medical Evidence Report form (CMS 2728) is used to register patients at the onset of ESRD, and must be submitted by dialysis or transplant providers within 45 days of treatment initiation. It establishes Medicare eligibility for individuals who previously were not Medicare beneficiaries, reclassifies previously eligible Medicare beneficiaries as ESRD patients, and provides demographic and diagnostic information for all new ESRD patients regardless of Medicare entitlement. CMS, USRDS, and renal research communities rely on the form to ascertain patient demographics, primary diagnosis, comorbidities, and biochemical test results at the time of ESRD onset.

Prior to 1995, dialysis units and transplant centers were required to file the Medical Evidence Report form only for Medicare-eligible patients. Since the 1995 revision, however, providers are required to complete the form for all new ESRD patients regardless of Medicare eligibility status. The 1995 revised form included new fields for comorbid conditions, employment status, expanded race categories, ethnicity, and biochemical data at ESRD onset. The third major revision of the Medical Evidence form in May 2005 remedied several shortcomings of the 1995 form and its earlier versions and is described in more detail in the next section. Key additions target pre-ESRD care and vascular access use, and additional new fields collect information on glycosylated hemoglobin (HgbAuc) and lipid testing, on the frequency of hemodialysis (HD) sessions, and on whether patients are informed of transplant options. The Medical Evidence form is the only source of information about the cause of a patient’s ESRD. Because the list of diseases has been revised, the USRDS stores the codes from each version so that detail is not lost through conversion of one set of codes to the other.
Only one Medical Evidence form (CMS 2728) is expected for each ESRD patient for the entire ESRD treatment period; however, multiple forms may be filed for patients whose insurance eligibility changes due to therapy changes. For example, transplant patients with functioning grafts after three years lose Medicare benefits if ESRD was the sole qualification for Medicare eligibility. If such a patient experiences graft failure and returns to dialysis, a second Medical Evidence Report must be filed to reestablish Medicare eligibility. Dialysis patients who discontinue dialysis for more than 12 months also lose Medicare ESRD benefits. If such a patient returns to dialysis or undergoes kidney transplant, a second Medical Evidence form must be filed to reestablish Medicare eligibility.

**2005 Revision of the Medical Evidence Report Form (CMS 2728)**

The revision of the Medical Evidence Report form (CMS 2728) introduced in May 2005 includes new data collection methods and new variables. It allows users to specify whether the Medicare registration is initial (new ESRD patient), re-entitlement (reinstating Medicare entitlement after a lapse due to no claims being filed for 12 or more months or a functioning graft for 36 or more months), or supplemental (updating missing or incorrect information). This clarifies the intended use of the form without recourse to the “First Regular Dialysis Start Date,” and helps chronicle the historical sequence of multiple forms for the same patient.

Multiple races can be specified. CMS provides a single variable containing a concatenated string representing all selected race codes with binary digits (0, 1). This string must be decoded to determine patient race (or races). Similar formatting requirements apply to information on comorbid conditions, medical coverage, and reasons for not informing patients of transplant options. Because the required programming is substantial, we include, for each of these four data categories, the original variable with the concatenated string and a new variable with the decoded values (i.e., information noted on form CMS 2728). However, the decoded multiple race values must be presented as “Other” or “Multiple race” to maintain consistency with the legacy race information.

Data fields for nephrologist care, dietitian care, and access type were also added, with their respective time intervals relative to ESRD onset. Data on the laboratory values hematocrit, creatinine clearance, BUN, and urea clearance are no longer collected. Added laboratory values are HbA1c and lipid profiles (TC, LDL, HDL cholesterol, and TG). Additional fields relate to whether patients were informed of transplant options, and if not, why not, and donor type. Comorbid conditions and primary diagnoses were also added. Both the 2005 and 1995 versions of the CMS 2728 form are provided in the USRDS Core SAF dataset and are available in the USRDS Researchers’ Guide, Appendix D: Data Collection Forms on the USRDS website: [www.usrds.org/research.aspx](http://www.usrds.org/research.aspx).
CMS ESRD DEATH NOTIFICATION FORM (CMS 2746)

The ESRD Death Notification form (CMS 2746) is used to report the death of ESRD patients. According to CMS policy, this form must be submitted by dialysis or transplant providers within 30 days of a patient’s death, and provides the date and causes of death (primary and secondary), reasons for discontinuation of renal replacement therapy, if applicable, and evidence of hospice care prior to death. It is the primary source of death information for CMS and the USRDS, documenting more than 99 percent of deaths. The USRDS also utilizes several supplemental data sources for ascertaining date and cause of death.

CMS MEDICARE ENROLLMENT DATABASE

The CMS Medicare EDB is the designated repository of all Medicare beneficiary enrollment and entitlement data, including current and historical information on beneficiary residence, Medicare as Secondary Payer (MSP) status, and Health Insurance Claim/Beneficiary Identification Code (HIC/BIC) cross-referencing.

CMS PAID CLAIMS RECORDS

Inpatient transplant and outpatient dialysis claims records are sometimes used to identify new ESRD patients for whom no Medical Evidence Report form has been filed. These patients are most likely to be non-Medicare patients or beneficiaries already receiving Medicare because of age or disability. They will eventually be entered into the CROWNWeb database, and hence the USRDS database, through the claims records.

For patients without Medical Evidence Reports, these claims are the only reliable information from which to determine first ESRD service dates. These paid claims records, however, only supplement and do not replace other sources of information on incidence and prevalence. Bills for some Medicare-eligible patients may not be submitted to or paid by Medicare. These patients are MSP patients covered by private insurance, HMOs, Medicaid, or the Department of Veterans Affairs (DVA).

ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK DATABASE

CMS began collecting data on all Medicare kidney transplants in the early 1980s. In 1984, the National Organ Transplant Act called for the creation of an Organ Procurement and Transplant Network (OPTN) to collect data and maintain a registry for organ matching and transplantation. The United Network for Organ Sharing (UNOS) was awarded the OPTN contract in 1988 to provide a national system for allocating donor organs and to maintain a centralized data depository for organ transplants. OPTN also began collecting data on all transplants. The OPTN and CMS collection efforts were consolidated in 1994, and only the OPTN continued to collect data on transplant donors and recipients.
CMS ESRD Standard Analytical Files

The CMS ESRD Standard Analytical Files (SAFs) contain data from final action claims submitted by Medicare beneficiaries, in which all adjustments have been resolved. For Part A Institutional Claims, the USRDS uses the following 100% SAF claims:

- Inpatient
- Outpatient
- Skilled Nursing Facility
- Home Health Agency
- Hospice

For Part-B Physician/Supplier, the USRDS uses the following 100% SAF claims:

- Physician/Supplier
- Durable Medical Equipment

CMS SAFs are updated each quarter through June of the following year, when the annual files are finalized. Datasets for the current year are created six months into the year and updated quarterly until finalized at 18 months, after which files are frozen and will not include late arriving claims. Annual files are thus approximately 98% complete. The USRDS 2015 SAF includes all claims up to December 31, 2013. Patient-specific demographic and diagnosis information, however, includes data as recent as June 2015.

CMS 5% General Medicare SAF

The 5% general Medicare SAF has the same structure and data elements as the ESRD 100% SAF, but the data were extracted from the general Medicare billing database as a random sample of 5% of the entire Medicare population. Because the sample is selected using the last two digits of patient Social Security Numbers, one should expect to see the same group of Medicare beneficiaries represented in the 5% SAFs each year, with exceptions for death, disenrollment, and new Medicare entitlements.

The USRDS Coordinating Center uses these files to conduct studies on Healthy People 2020 objectives, comparing preventive care and other non-ESRD disease treatments in general Medicare and ESRD patients. In addition, these files are used to create the CKD cohort dataset.

Clinical Performance Measures (CPM) Project

CMS developed the ESRD CPM (formerly the ESRD Core Indicators Project) to collect information on the quality of care provided to dialysis patients. The data originate from surveys completed by primary care facilities, and focus on dialysis adequacy measures, anemia management, and vascular access use. Additional clinical parameters such as albumin are also available. These data were collected annually.
beginning in 1994, using a random sample of patients aged 18 years and older, alive and on dialysis at the end of each calendar year; on average, about 8,500 in-center hemodialysis patients and 1,500 peritoneal dialysis patients were surveyed each year. Data collection for all pediatric patients aged 12 to 17 years began in 2000, and in 2002 was expanded to all in-center hemodialysis patients aged younger than 18 years. Starting in 2005, all peritoneal dialysis (PD) patients in the United States were sampled for the pediatric PD data collection. In anticipation of the national release of the CROWNWeb system and its supporting performance measures reports, CMS concluded its CPM project in 2009, making 2008 its final survey year. TheUSRDS Coordinating Center, in collaboration with CMS, provides CPM/USRDS merged data to the general research community.

**CMS Dialysis Facility Compare Data**

The USRDS uses the CMS Dialysis Facility Compare data to define chain and ownership information for each renal facility. Before the 2003 ADR, similar data were extracted from the Independent Renal Facility Cost Report (CMS 265-94).

**CMS Annual Facility Survey**

In addition to the CMS ESRD databases, independent ESRD patient counts are available from the CMS Annual Facility Survey [AFS] (CMS 2744), which all Medicare-certified dialysis units and transplant centers are required to complete at the end of each calendar year. The AFS reports counts of patients being treated at the end of the year, new ESRD patients starting during the year, and patients who died during the year. Counts of Medicare and non-Medicare end-of-year patients are included. While AFS files do not carry patient-specific demographic and diagnosis information, they do provide independent patient counts used to complement the CMS patient-specific records.

**CDC National Surveillance Data**

From 1993–1997 and 1999–2002, the CDC used its survey National Surveillance of Dialysis-Associated Diseases in the United States to collect information from dialysis facilities on patient and staff counts, membrane types, reuse practices, water treatment methods, therapy types, vascular access use, antibiotic use, hepatitis vaccination and conversion rates (for both staff and patients), and the incidence of HIV, AIDS, and tuberculosis. None of the information is patient-specific. Because the CDC terminated this program in 2003, the last surveillance report is for 2002 data. The CDC did not conduct a survey in 1998.

**Dialysis Morbidity and Mortality Study**

The Dialysis Morbidity and Mortality Study (DMMS) was an observational study that collected data on demographics, comorbidity, laboratory values, treatment, socioeconomic factors, and insurance for
a random sample of U.S. dialysis patients, using dialysis records. Data were collected on 6,000 ESRD patients in each of Waves I, III, and IV, and 4,500 patients in Wave II, a total of 22,500 patients over three years. Waves I, III, and IV are each historical prospective studies in which data were collected for patients receiving in-center hemodialysis on December 31, 1993. Data were abstracted from patient medical records, and each patient was followed from December 31, 1993, through the earliest of data abstraction, death, transplant, change in modality, or transfer to another facility. Wave II is a true prospective study of incident hemodialysis and peritoneal dialysis patients for 1996 and some incident patients entering the ESRD program in the first part of the 1997 calendar year.

**Case Mix Adequacy Study**

The objectives of the USRDS Case Mix Adequacy Study (CMAS) of Dialysis were to:

- Establish the relationship between the dose of delivered dialysis therapy and mortality
- Determine the strength of this relationship when data are adjusted for comorbidity
- Assess how this relationship changes at different dialysis doses
- Assess how this relationship is affected by dialyzer reuse
- Assess the impact of different dialysis membranes on patient morbidity and mortality

The study consisted of two groups of patients: an incident sample of ESRD patients who began hemodialysis during 1990, and a prevalent sample of hemodialysis patients with ESRD onset before 1990. A total of 7,096 patients from 523 dialysis units were included, the pre- and post-BUN values needed to calculate delivered dialysis dose were present for approximately 3,300 patients. Ninety-four percent of these cases were matched to the USRDS database. The ESRD Networks collected these data in conjunction with their Medical Case Review data abstraction.

**Case Mix Severity Study**

The objectives of this study were to:

- Estimate the correlation of comorbidity and other factors present at ESRD onset with subsequent mortality and hospitalization rates, adjusting for age, sex, race, and primary diagnosis
- Evaluate possible associations of these factors with reported causes of death
- Assess the distribution of comorbidity and other factors among patients using different treatment modalities
- Compare relative mortality rates by treatment modality, adjusting for selected comorbid conditions and other factors

Data were collected for 5,255 incident patients in 1986 and 1987 at 328 dialysis units nationwide.
**Pediatric Growth and Development**

The objectives of the USRDS Pediatric ESRD Growth and Development Study were to:

- Establish a baseline for assessing the relation of pediatric ESRD patient growth and sexual maturation to modality
- Establish a prototype for the ongoing collection of pediatric data

All patients prevalent in 1990 and born after December 31, 1970, were included in the study, a total of 3,067 patients at 548 dialysis units.

**Continuous Ambulatory Peritoneal Dialysis and Peritonitis Study**

The USRDS Continuous Ambulatory Peritoneal Dialysis (CAPD) and Peritonitis Rates Study examined the relation of peritonitis episodes in CAPD patients to connection device technology and other factors. The study population included all patients newly starting CAPD in the first six months of 1989, up to a maximum of 14 patients per dialysis unit. All units providing CAPD training participated in the study. The sample includes 3,385 patients from 706 units.

**U.S. Census**

The U.S. population data are from the 2000 and 2010 U.S. Census, and also incorporate CDC postcensal and intercensal population estimates. The data and methods for these estimates are available at [http://www.cdc.gov/nchs/nvss/bridged_race.htm](http://www.cdc.gov/nchs/nvss/bridged_race.htm). Both intercensal and postcensal estimate datasets are available at [http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm](http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm). USRDS summarizes the data with different race categories at state and national levels.

**USRDS ESRD Database System**

The USRDS Coordinating Center has developed a centralized ESRD patient database by integrating data from the above data sources and establishing methods to identify patients with ESRD. We use this database to update and maintain data on demographics, clinical measurements, biochemical lab test results, renal replacement therapy, treatment history, and all medical service events reported in the Medicare Claims database. Through this patient-oriented database we attempt to define each individual ESRD patient through multiple stages of data cleaning, conversion, validation, and consolidation. Establishment of a universal patient identification system was critical to ensure that unique patient identification numbers are assigned to each ESRD patient at the time of ESRD initiation, and to accurately track counts and rates of incident and prevalent cohorts over time.

In 1994, the USRDS Coordinating Center introduced the Standard Analysis Files (SAFs)—not to be confused with the CMS Standard Analytical Files for Part A and Part B Claims data—to help meet the ESRD data needs of a wide variety of research studies. These SAFs were subsequently enhanced to
include not only ESRD clinical and claims data from CMS, but also transplant and waiting list data from OPTN. All SAFs are indexed or sorted by the unique USRDS-specified patient identification number, and patient identifiers (name, address, SSN, HIC/BIC, etc.) are removed to protect patient confidentiality. The USRDS Coordinating Center also uses the USRDS ESRD database to generate datasets used within the tables, graphs, and maps in the USRDS ADR.

The USRDS ESRD database is updated quarterly with data obtained from the various data sources. The USRDS Coordinating Center generally receives CMS SAF claims, Facility Survey, Patient Lists and Patient Events, Medical Evidence Report, and Death Notification data, on a quarterly basis. We receive OPTN transplant and waiting list data monthly. The Medicare EDB is currently updated annually, although we will be moving toward more frequent updates. These multiple updates allow the USRDS Coordinating Center to assess growth of the ESRD population, the demographic distribution of ESRD patients, and changes in the percent of patients diagnosed with major diseases secondary to ESRD.

Section 2: ESRD Patients

ESRD is defined as chronic renal failure requiring renal replacement treatment — dialysis or transplant — to sustain life. It is not the same as acute renal failure, from which patients are expected to recover within weeks or months. A Medical Evidence Report must be completed immediately by renal providers for all ESRD patients to register them in the CMS ESRD database and to apply for Medicare eligibility if they were not previously eligible.

To establish the incident and prevalent cohorts by year, modality, primary cause of renal failure, and other factors, patient demographic and clinical information are required, as well as treatment history data. This information can be obtained from the USRDS Core SAF dataset from the following files: PATIENTS, MEDEVID, RXHIST, RXHIST60, and PAYHIST.

Identifying ESRD Patients

A person is identified as having ESRD when a physician certifies the disease on the Medical Evidence Report form (CMS 2728), or when other evidence of chronic dialysis or kidney transplant exists. Patients with acute kidney failure who are on dialysis for days or weeks, but who then recover kidney function, are excluded from the database if their Medical Evidence forms have not been submitted. Patients who die soon after kidney failure without receiving dialysis are sometimes missed.
First ESRD Service Date

The first ESRD service date (FSD) is the single most important data element in the USRDS database, and each patient must, at a minimum, have a valid FSD. This date is used to determine each new patient’s incident year and the first year in which the patient is counted as prevalent. The date 90 days after the FSD is used as the starting point for many patient survival outcomes analyses. This 90-day rule allows each new ESRD patient to obtain Medicare services despite potential delays in completing the Medicare eligibility application process, and it provides an adequate time period for patients to arrive at a stable and suitable dialytic treatment modality.

In most cases, the first service date is derived by identifying the earliest date of various potential indicators:

- The start of dialysis for chronic kidney failure as reported on the Medical Evidence form
- The first CROWNWeb/SIMS event
- A kidney transplant as reported on a CMS or OPTN transplant form, a Medical Evidence form, or a hospital inpatient claim, or
- The first Medicare dialysis claim

There are two exceptions to the first ESRD service date determination:

- If the CROWNWeb/SIMS event and Medical Evidence form agree (within 30 days of each other) and are more than 90 days after the first Medicare dialysis claim, and, if in addition, there is no transplant event between the first dialysis claim and the earlier of the CROWNWeb/SIMS event date and Medical Evidence form date, then first service date is defined as the earlier of the CROWNWeb/SIMS event date and Medical Evidence form date.
- If the Medical Evidence form date is one year earlier than the first CROWNWeb/SIMS event date, and if the first claim date or first transplant date agrees with the first CROWNWeb/SIMS event date, then the CROWNWeb/SIMS first event date is used as the first service date.

Death Date Determination

After the ESRD first service date, the date of death is the most critical piece of information in the ESRD database. Death dates are obtained from several sources, including the CMS Medicare Enrollment Database, CMS forms 2746 and 2728, OPTN transplant follow-up form, CROWNWeb database, Social Security Death Master File, and Inpatient Claims. Because multiple sources report death information for the same patient, one patient may have several reported dates. For these patients, the death date is based on the hierarchy order below, with lower numbers having a higher priority:
1. CMS form 2746 Death Notification
2. CMS Enrollment Database
3. CROWNWeb Events
4. OPTN Transplant data
5. CMS Form 2728 Medical Evidence
6. CMS Institutional Claims
7. CMS Patient List

Transplant Dates

The CMS and OPTN Transplant data files overlap for 1988–1993, and transplants are also identified from Medical Evidence forms that indicate transplant as the initial modality, from CROWNWeb transplant events, and from institutional inpatient claims. To resolve any conflicts among these three sources, the USRDS has adopted the following procedure:

- Before 1988, all transplant events found in CMS PMMIS/REBUS/REMIS Transplant Files are used.
- After 1994, all transplant events found in OPTN Files are used.
- Between 1988 and 1993, all transplant events found in OPTN Files are used, and additional transplant events from the CMS PMMIS/REBUS/REMIS Transplant File are used only if they occur at least 30 days on either side of a previously accepted transplant event.
- Additionally, transplant events associated with reported incident transplant patients from the Medical Evidence Report are used if they occur at least 30 days before or after a previously accepted transplant event. Transplant events found in CMS Inpatient claims records are also included as transplants found in the CROWNWeb patient events data.

Each transplant event found in the Transplant File of the USRDS Core SAF dataset is thus a unique event derived from the OPTN database, the CMS Transplant database, Medical Evidence Report records, CROWNWeb patient events, or Institutional Claims Files.

Graft Failure

The USRDS Coordinating Center assumes that a graft failure date reported in the OPTN transplant follow-up file or the REMIS identification file is correct unless death or a new transplant occurs before this date. However, a graft failure date may be unrecorded in both files. In this case, the USRDS Coordinating Center derives the graft failure date from the following sources:
• Date of death
• Date of subsequent transplant
• Date of return to regular dialysis, indicated by a continuous period of dialysis billing records covering a minimum of 60 days with at least 22 reported dialysis treatments
• Date of return to dialysis reported on the Medical Evidence Report, or the date of graft nephrectomy from the OPTN transplant follow-up record or a Medicare claim
• If no failure date is available, then the earliest of the above dates is used as the graft failure date

Medicare and Non-Medicare Patients

Beneficiaries are enrolled in Medicare based on criteria defined in Title XVIII of the Social Security Act of 1965 and in subsequent amendments to the Act. A person in one of these four categories is eligible to apply for Medicare entitlement:

• Aged 65 years and older
• Disabled
• Enrolled in the ESRD program
• Railroad Retirement Board (RRB)

Most ESRD patients are eligible to apply for Medicare as their primary insurance payer. Some, however, are not immediately eligible for Medicare primary payer coverage because of their employment status and pre-existing primary insurance payers. These are covered by payers such as Employer Group Health Plans (EGHPs), the Department of Veteran Affairs, and private insurers. Typically, these patients wait 30–33 months before becoming eligible for Medicare as primary payer, and are not included in the Medicare EDB database during the waiting period. Many of these patients, particularly those who are new since 1995, have FSDs established by Medical Evidence Reports, even though they have no dialysis claims or hospitalization events in the CMS claims database. Treatment history events can be tracked by the CROWNWeb Patient Events File, which follows changes in modality, transplants, transfers between facilities, and death. In the REMIS database, all non-Medicare ESRD patients are designated “ZZ” in the two-character Beneficiary Identification Code field. All ESRD patients, regardless of their Medicare Eligibility status, are in the CROWNWeb system.

The USRDS recognizes that these non-Medicare (“ZZ”) patients are ESRD patients and should therefore be included in patient counts for incidence, prevalence, and treatment modality, as well as mortality and transplant rate calculations. Calculations of hospitalization statistics, or possibly of any outcomes derived from Medicare claims including outpatient claims or in any other setting, however, should not include these patients because of the small number of claims available in the
first 30 to 33 months after first ESRD service (for more information, see Section 4: Payer History). Refer to syntax on creating a Medicare primary cohort in Example 9: Create a Patient Cohort of 2008 Medicare Primary Incident Patients as a guide.

**Section 3: Treatment History**

The USRDS uses all available data to create a treatment history for each patient in the database, including all modality events, their duration, and the renal providers involved in each patient’s care. This history can be used to identify incident and prevalent cohorts and determines censoring points and outcomes for observational studies. The CROWNWeb event database is the primary source of the modality sequence file, and the dialysis claims are used as a way of confirming placements and identifying problem cases. As described in the previous section, we use all available sources to determine first service dates, deaths, transplants, and transplant failures.

**Treatment Modality Categories**

Table 12 lists modality categories used by the USRDS. They can be described as detailed or general. For most analyses, the general categories, which combine detailed modality categories, are sufficient. The RRF modality/event is similar to the lost-to-follow-up event in that patients with an RRF event are not included in the prevalent populations for outcomes analyses. However, as with lost-to-follow-up events, these patients remain in the modality sequence so that subsequent renal episodes can be closely tracked in a timely manner.
Table 12. Treatment modality categories

<table>
<thead>
<tr>
<th>Type</th>
<th>Detailed</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Center HD</td>
<td>HD</td>
</tr>
<tr>
<td>2</td>
<td>Center Self HD</td>
<td>HD</td>
</tr>
<tr>
<td>3</td>
<td>Home HD</td>
<td>HD</td>
</tr>
<tr>
<td>4</td>
<td>HD Training</td>
<td>HD</td>
</tr>
<tr>
<td>5</td>
<td>CAPD</td>
<td>PD</td>
</tr>
<tr>
<td>6</td>
<td>CAPD Training</td>
<td>PD</td>
</tr>
<tr>
<td>7</td>
<td>CCPD</td>
<td>PD</td>
</tr>
<tr>
<td>8</td>
<td>CCPD Training</td>
<td>PD</td>
</tr>
<tr>
<td>9</td>
<td>Other PD</td>
<td>PD</td>
</tr>
<tr>
<td>A</td>
<td>Uncertain Dialysis</td>
<td>Unknown Dialysis</td>
</tr>
<tr>
<td>B</td>
<td>Discontinued Dialysis</td>
<td>Discontinued Dialysis</td>
</tr>
<tr>
<td>T</td>
<td>Functioning Tx</td>
<td>Transplant</td>
</tr>
<tr>
<td>X</td>
<td>Lost to follow-up</td>
<td>Lost to follow-up</td>
</tr>
<tr>
<td>Z</td>
<td>Recovered Function</td>
<td>Recovered Function</td>
</tr>
</tbody>
</table>

**How Treatment Modality is Determined**

The Treatment History Files in the USRDS Core SAF dataset record the sequence of modalities for each patient. The variables included in these files are presented in Table 13. Each record in the file indicates a period of therapy with a given modality, and any change in provider or detailed modality results in a new record. Several data sources are used to determine the treatment history, including the Medical Evidence file, the CROWNWeb Event file, the OPTN Transplant Events File, Medicare Claims Files, and Death Notification forms (CMS 2746).
Table 13. Treatment history SAF variables

<table>
<thead>
<tr>
<th>File name</th>
<th>Variable name</th>
<th>Variable label</th>
</tr>
</thead>
<tbody>
<tr>
<td>RXHIST (Detailed Treatment History)</td>
<td>USRDS_ID</td>
<td>USRDS patient identification</td>
</tr>
<tr>
<td></td>
<td>BEGDATE</td>
<td>Beginning date of a modality period</td>
</tr>
<tr>
<td></td>
<td>ENDDATE</td>
<td>Ending date of a modality period</td>
</tr>
<tr>
<td></td>
<td>BEGDAY</td>
<td>Start day of modality period (First Service Date = 1)</td>
</tr>
<tr>
<td></td>
<td>ENDDAY</td>
<td>End day of modality period (First Service Date = 1)</td>
</tr>
<tr>
<td></td>
<td>RXDETAIL</td>
<td>Detailed treatment modality for period</td>
</tr>
<tr>
<td></td>
<td>RXGROUP</td>
<td>Grouped treatment modality for period</td>
</tr>
<tr>
<td></td>
<td>PROVUSRD</td>
<td>USRDS assigned facility identification</td>
</tr>
<tr>
<td></td>
<td>DEATH</td>
<td>Death: 1 if enddate=deathdate; 0 if alive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>File name</th>
<th>Variable name</th>
<th>Variable label</th>
</tr>
</thead>
<tbody>
<tr>
<td>RXHIST60 (Condensed Treatment History)</td>
<td>USRDS_ID</td>
<td>USRDS patient identification</td>
</tr>
<tr>
<td></td>
<td>BEGDATE</td>
<td>Beginning date of a modality period</td>
</tr>
<tr>
<td></td>
<td>ENDDATE</td>
<td>Ending date of a modality period</td>
</tr>
<tr>
<td></td>
<td>BEGDAY</td>
<td>Start day of modality period (First service date = 1)</td>
</tr>
<tr>
<td></td>
<td>ENDDAY</td>
<td>End day of modality period (First service date = 1)</td>
</tr>
<tr>
<td></td>
<td>RXGROUP</td>
<td>Grouped treatment modality for period</td>
</tr>
<tr>
<td></td>
<td>DEATH</td>
<td>Death: 1 if enddate=deathdate; 0 if alive</td>
</tr>
</tbody>
</table>

In constructing this Treatment History File (RXHIST), these conventions are followed:

- The sequence always begins with the first ESRD service date and ends with the earliest of date of death or end of the period for which the data are complete. Other categories always have an end date. If patient is still alive, the end date of last period is assigned a study end date “6/30/2015”.
- If two dialysis billing periods overlap, the earlier is terminated at the start of the later.
- A functioning transplant is considered treatment, not recovery from ESRD.
- If a dialysis billing period overlaps a transplant date, the dialysis period is closed at the transplant date.
- If a graft failure is recorded in the database, but there are no subsequent records of dialysis, or death, or death or another transplant, a period of “unknown dialysis” is inserted. If no dialysis billing records or re-transplant appears within one year, the patient is designated as lost-to-follow-up at the end of a one-year period, and this status continues until dialysis or new transplant records appear.
- Once established, a modality is assumed to continue until a change in provider or detailed modality occurs. For dialysis patients, if no new dialysis billing data appear for one year, the patient is reclassified as lost-to-follow-up at the end of that one-year period.
A functioning graft is assumed to continue until an indication of graft failure or death appears, or evidence of regular or maintenance dialysis.

The 60-Day Collapsing Rule

The USRDS Coordinating Center uses the convention that a dialysis modality must continue for at least 60 days to be considered stable. A transplant is considered a stable modality regardless of duration.

Because the dialysis treatment history is derived from the CROWNWeb Events File, the Medical Evidence Report, OPTN Transplant Events, and Medicare billing records, it includes intermixed and overlapping details that are not required or are unsuitable for most analyses. A long period of CAPD, for example, may be interrupted by a short period of inpatient hemodialysis treatment, or a patient may go on vacation and receive dialysis from a different provider. By applying the 60-day rule, we collapse modality periods of less than 60 days, and periods that differ only by provider, giving a less complex treatment history for analyses that require less detail than is available in the detailed treatment history. For maximum flexibility, we provide two Treatment History Files, one with full detail (RXHIST), and one applying the 60-day collapsing rule (RXHIST60). Tables 14 and 15 show examples of how these two files differ. The 60-day file is constructed from the detailed file as follows:

- Consecutive records with the same dialysis modality group are collapsed into a single record regardless of the length of period, detailed dialysis modalities as well as changes in provider. Thus the collapsed file cannot be used to track the changes of provider and detailed dialysis modalities within the same general dialysis modality group.

- For events with period less than 60 days, the dialysis modality periods are labeled 'uncertain dialysis' and consecutive dialysis records labeled 'uncertain dialysis' are combined. This rule does not applied to functioning transplant and other non-dialysis modalities.

- If a dialysis modality is interrupted by a different dialysis modality that lasts < 60 days (e.g., a period of peritoneal dialysis between two longer periods of hemodialysis), the short dialysis modality period is ignored and the longer dialysis modality extends over the entire period. This rule does not applied to functioning transplant and other non-dialysis modalities.
Table 14. RXHIST examples

<table>
<thead>
<tr>
<th>USRDS_ID</th>
<th>BEGDATE</th>
<th>ENDDATE</th>
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<th>DEATH</th>
<th>RXDETAIL</th>
<th>RXGROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2/10/1992</td>
<td>6/1/1992</td>
<td>922</td>
<td>0</td>
<td>Hemodialysis</td>
<td>Hemodialysis</td>
</tr>
<tr>
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<td>6/2/1992</td>
<td>1/16/1994</td>
<td>922</td>
<td>1</td>
<td>CAPD</td>
<td>CAPD</td>
</tr>
<tr>
<td>6</td>
<td>2/7/1974</td>
<td>6/12/1974</td>
<td>1355</td>
<td>0</td>
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<td>CAPD</td>
</tr>
<tr>
<td>6</td>
<td>6/13/1974</td>
<td>3/30/2008</td>
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<td>Transplant</td>
<td>Transplant²</td>
</tr>
<tr>
<td>6</td>
<td>3/31/2008</td>
<td>4/21/2008</td>
<td>7635</td>
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<td>CAPD b</td>
</tr>
<tr>
<td>6</td>
<td>4/22/2008</td>
<td>9/5/2008</td>
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<td>Hemodialysis</td>
</tr>
<tr>
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<td>9/6/2008</td>
<td>10/5/2008</td>
<td>5130</td>
<td>1</td>
<td>Hemodialysis</td>
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<tr>
<td>7</td>
<td>3/20/1981</td>
<td>4/12/1981</td>
<td>1822</td>
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<td>Hemodialysis</td>
<td>Hemodialysis</td>
</tr>
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<td>7/6/1981</td>
<td>10/1/1981</td>
<td>1822</td>
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<td>Hemodialysis</td>
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<td>9/7/1982</td>
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<td>Hemodialysis</td>
</tr>
<tr>
<td>8</td>
<td>9/12/1983</td>
<td>9/30/1983</td>
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<td>0</td>
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<tr>
<td>8</td>
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<td>2081</td>
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<td>CAPD</td>
</tr>
<tr>
<td>8</td>
<td>1/1/1984</td>
<td>6/19/1984</td>
<td>2081</td>
<td>0</td>
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<td>CAPD</td>
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<td>8</td>
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<td>2081</td>
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</tr>
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</table>
Table 15. RXHIST60 examples

<table>
<thead>
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<th>ENDDATE</th>
<th>DEATH</th>
<th>RXGROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2/10/1992</td>
<td>6/1/1992</td>
<td>0</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>5</td>
<td>6/2/1992</td>
<td>1/16/1994</td>
<td>1</td>
<td>CAPD</td>
</tr>
<tr>
<td>6</td>
<td>2/7/1974</td>
<td>6/12/1974</td>
<td>0</td>
<td>CAPD</td>
</tr>
<tr>
<td>6</td>
<td>6/13/1974</td>
<td>3/30/2008</td>
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<td>Transplant&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
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<td>1</td>
<td>Hemodialysis</td>
</tr>
<tr>
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<td>6/5/1981</td>
<td>7/5/1981</td>
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<td>Transplant&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>7</td>
<td>7/6/1981</td>
<td>9/7/1982</td>
<td>0</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>7</td>
<td>9/8/1982</td>
<td>4/8/1998</td>
<td>0</td>
<td>Transplant&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>7</td>
<td>4/9/1998</td>
<td>4/10/1998</td>
<td>1</td>
<td>Uncertain Dialysis&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>8</td>
<td>9/12/1983</td>
<td>6/19/1984</td>
<td>0</td>
<td>CAPD</td>
</tr>
<tr>
<td>8</td>
<td>6/20/1984</td>
<td>7/17/1984</td>
<td>0</td>
<td>Transplant&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>8</td>
<td>7/18/1984</td>
<td>3/10/1985</td>
<td>1</td>
<td>CAPD</td>
</tr>
</tbody>
</table>

<sup>a</sup> The 60-day rule does not apply to transplants.
<sup>b</sup> CAPD record less than 60 days in RHIST, collapsed down with next dialysis modality in RXHIST60.
<sup>c</sup> Hemodialysis record less than 60 days in RHIST. It is the patient’s last record, with previous event “Transplant,” so it cannot be collapsed down or up with previous or next event. Recode to “Uncertain Dialysis” in RXHIST60.

Integration of the CROWNWeb and CMS Claims Databases

For patients who either do not appear in the CROWNWeb Events File or for whom the only event is “New ESRD Patient,” and patients who have transfer-out gaps, the Medicare dialysis claims file is used. For “Transfer Out” and “Transfer Out for a Transplant” events with large gaps (seven days or more), claims falling in gaps are included, with the exception that no claims data are included if the “Transfer Out for a Transplant” event has a corresponding transplant/ transplant failure event that occurred within (before or after) 30 days. Claims data are also included for the periods after “Transplant Failure” events and “Discontinued Dialysis” modality if the periods are longer than seven days.

Because the claims data capture the modality “Center Self Hemodialysis” more accurately than the CROWNWeb data, this claims-based designation overrides other dialysis modalities from CROWNWeb. Any CROWNWeb dialysis event that falls into a “Center Self Hemodialysis” period as determined by claims is recoded as “Center Self Hemodialysis.”

Some events that do not make sense are removed. These include events that occur before a patient’s first service date, those falling between “Transplant” and “Transplant Failure,” “Transfer Out for A Transplant” events that occur 60 days or less after the corresponding “Transplant,” and events occurring after “Death.”
**Determining Lost-to-Follow-up Periods**

Gaps frequently exist in the CROWNWeb and billing data upon which modality periods are based. The USRDS assumes that a modality continues until death or the next modality-determining event. A patient with a functioning transplant is assumed to maintain it unless a new CROWNWeb event, claim event, or death date is encountered in the data. A dialysis modality, in contrast, is assumed to continue for only 365 days from the date of the last claim, in the absence of a death date or dialysis claims. After this period the patient is declared lost-to-follow-up, until the occurrence of a new CROWNWeb event, dialysis claim, or transplant event.

Patients are considered lost-to-follow-up beginning 365 days after a “Transplant Failure” event or “Discontinued Dialysis” modality. Patients for whom the only event is a first service date, and who do not exist in any other files were also treated as lost-to-follow-up, beginning one year after the first service date. A number of events can result in a lack of dialysis data and eventual reclassification of a patient as lost-to-follow-up:

- The patient may have recovered renal function (RRF) and many no longer have ESRD.
- The patient may no longer reside in the United States.
- The patient’s death may not have been reported to the Social Security Administration or to CMS.

**Section 4: Payer History**

**ESRD Payer Sequence File**

The ESRD Payer History File is similar to the Treatment History File. CMS payer information is used to create a continuous sequential history of payers for each patient in the ESRD database, beginning with the first ESRD service date. Each patient’s FSD in the Payer History File is the same date reported in the Treatment History File. Data from the Medicare Enrollment Database and dialysis claims information are used to categorize payer status as Medicare primary payer (MPP), MSP, or non-Medicare. The claims database contains data only for MPP and MSP patients, so claims-based analyses, such as analyses of cost and hospitalization, will not include non-Medicare patients. Non-Medicare patients therefore must be identified and excluded when determining numbers of patients or patient years at risk for analyses of cost per patient or hospitalization rates. In addition, as it is impossible to determine the complete hospitalization history or complete cost of care for ESRD patients with MSP coverage, such analyses should also exclude patients during the periods when they have this coverage. The Payer History file can be used to make these exclusions.
Pre-ESRD Payer Sequence File

The Pre-ESRD Payer Sequence File can be used to determine payer status for the periods prior to first ESRD service date. This Payer Sequence File is similar to the standard ESRD Payer Service File except that the Pre-ESRD Payer Sequence file begins at the first evidence of Medicare enrollment from the Enrollment Database, rather than first ESRD service date, as is the case with the ESRD payer sequence. The pre-ESRD payer sequence ends the day before the first ESRD service date.

Data Sources

The payer for any given time period is determined by evaluating several data sources. The Medicare EDB is used to determine Part A, Part B, Group Health Organization, MSP Primary Payer, Third Party Part A, and Third Party Part B payers. The CMS claims billing files provide dates of regular maintenance dialysis, used as an indicator of Medicare as primary payer. The PATIENTS file in the USRDS Core SAF dataset contains dates of death, used to help establish the end point of the payer sequence.

Payer Categories

Table 16 shows the payer categories used by the USRDS and indicates whether a patient is considered a Medicare patient (yes or no), and whether the patient has dual Medicare/Medicaid eligibility for that payer time period (yes or no).

<table>
<thead>
<tr>
<th>Medicare code</th>
<th>Medicare / Medicaid description</th>
<th>Medicare patient</th>
<th>Medicare / Medicaid dual eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPAB</td>
<td>Medicare Primary, Part A and Part B</td>
<td>Y</td>
<td>Y/N</td>
</tr>
<tr>
<td>MPO</td>
<td>Medicare Primary, Other</td>
<td>Y</td>
<td>Y/N</td>
</tr>
<tr>
<td>MSP-EGHP</td>
<td>Medicare as Secondary Payer with EGHP</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>MSP-nonEGHP</td>
<td>Medicare as Secondary Payer with no EGHP</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>HMO</td>
<td>Group Health Org</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>WAIT</td>
<td>90 Day Waiting Period</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>OTH</td>
<td>Other/Unknown</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

How the Payer Category is Determined

The Payer History File in the USRDS Core SAF dataset records the sequence of payers for each patient. Table 17 shows the variables included in this file. Each record in the file represents a time period
covered by a particular payer. Any change in payer, Medicare status, or dual eligibility status results in a new record. Note that the “WAIT” status can be either Medicare or non-Medicare, depending on the Medicare status of the sequence following the “WAIT” period.

Table 17. Payer History SAF variables

<table>
<thead>
<tr>
<th>Variable label</th>
<th>Variable description</th>
</tr>
</thead>
<tbody>
<tr>
<td>USRDS_ID</td>
<td>USRDS Patient Identification</td>
</tr>
<tr>
<td>BEGDATE</td>
<td>Beginning date of a payer period</td>
</tr>
<tr>
<td>ENDDATE</td>
<td>Ending date of a payer period</td>
</tr>
<tr>
<td>PAYER</td>
<td>Payer for the period</td>
</tr>
<tr>
<td>MCARE</td>
<td>Payer includes Medicare (Y/N)</td>
</tr>
<tr>
<td>DUALELIG</td>
<td>Payer includes Medicare and Medicaid (Y/N)</td>
</tr>
</tbody>
</table>

Because several data sources are used to determine payer history, more than one payer may be reported for any given time period. In constructing the history, the following conventions are followed:

- The sequence begins with the first ESRD service date. If the patient has died, the end date for the last patient record is the date of death. If the patient has not died, the end date is missing from the patient’s last record.
- The expected ESRD entitlement date is defined as the remainder of the month of incidence, plus two full calendar months. If the payer on the first service date is unknown, the patient is assumed to be in the waiting period prior to entitlement, and the first payer is assigned to the value “WAIT.” The “WAIT” period lasts until the expected entitlement date, or until another payer is identified. The Medicare status of the “WAIT” period is assumed to be the same as the Medicare status of the following period.
- If the reported end date for a payer is missing in the data source, the payer is assumed to continue sharing responsibility through the date of death or through the period of available payer information, whichever comes first.
- If more than one payer is identified for a time period, precedence for assigning the payer for the sequence is as follows: HMO, Medicare Primary if indicated by the claims billing file, MSP, then Medicare Primary if indicated by the Enrollment Database.
- If payer and dual eligibility status are the same in consecutive payer sequences, the sequences are collapsed into one time period, starting with the beginning date of the first and ending with the end date of the last.
Unlike the treatment history file, the Payer History File does not require a payer to continue for any specific time period to be considered stable, and all changes in payer are reported. At their discretion, users may apply additional rules to manage the payer history sequence.

**Gaps in the Payer History**

Some patient payer histories include gaps with Other/Unknown as payer between sequences with identified payers. This might occur for several reasons, similar to the explanations for gaps in the treatment history:

- Some patients recover enough renal function to discontinue dialysis and theUSRDS database may contain no payer information for non-dialysis time periods.
- Payer information for successful transplant patients may not be reported in the data sources because Medicare eligibility terminated after three years with a functioning graft.
- A patient may leave the country and become lost-to-follow-up.
- A patient may die and the death data may not reach theUSRDS.
- CMS may not have collected payer information.
- Reporting, data entry, and clerical errors may obscure the record of FSD and the corresponding payer.
- Errors in patient identification may cause data for a single patient to be split between two patients or to be associated with the wrong patient.

If a patient is alive but the last reported payer in the data sources ends on a date before the reported data extraction date, an additional payer sequence is created with Other/Unknown payer to extend the patient’s payer history. Thus, only patients who have died have end dates in their last payer sequences, and the last end date is the date of death.

Some patients have no identified payers. Their payer histories are represented in the file as one payer sequence, starting at first ESRD service date, with missing end date and Other/Unknown payer.

**Section 5: Medicare Claims**

**Introduction**

TheUSRDS Coordinating Center has created files from CMS billing data and incorporated them into theUSRDS database. These files include claims for some patients who are not included in the SAF.PATIENTS file and claims for some patients before the start of ESRD. These cases can be identified
CMS Data Sources

Medicare claims are of two types: Physician/Supplier Claims for all of Medicare Part B, and Institutional Claims primarily for Part A. Some Part B claims, however, are Institutional Claims, notably those for outpatient dialysis. The structure and content of the two types of claims are different, as are the files derived from them.

The Institutional Claims Files are obtained from the CMS Standard Analytical Files (SAFs), and the Physician/Supplier data are from the 100% National Claims History Nearline File. For ESRD claims data prior to 2012 and pre-ESRD claims data prior to 2010, information on outpatient dialysis and hospital inpatient stays not included in the CMS SAFs are obtained from PMMIS/REBUS/REMIS. Together, these sources provide data on all types of Medicare bills. The following CMS SAFs are used:

- Inpatient
- Outpatient
- Skilled Nursing Facility
- Home Health Agency
- Hospice

For Institutional and Physician/Supplier Claims Files, data for a given year is frozen at the end of June of the subsequent year, so claims submitted after June of the year following the year of service are not included. All data are resolved to final bills, with duplicates and correction transactions resolved into a single final bill for the service in question.

For ESRD claims data prior to 2012 and pre-ESRD claims data prior to 2010, the PMMIS/REBUS/REMIS system provides an alternate source of data on hospital inpatient stays and outpatient dialysis, but it includes no charge or payment data. The inpatient data include diagnosis and procedure codes, and outpatient data include summaries of dialysis claims by calendar quarter and provider. This is the only source for data from before 1989, the year in which the CMS SAFs start. Starting with 1991, data from PMMIS/REBUS/REMIS were used only when a matching hospital stay or dialysis record is not in the CMS SAFs; PMMIS/REBUS/REMIS data are distinguished by the value of the HCFASA variable (M or Q). SAF data were given preference because of their greater detail and are now the only source for ESRD claims. ESRD claims data from 2012 and pre-ESRD claims data from 2010 no longer include data from REMIS summarized files.
CMS Institutional SAFs (Part A) and Physician/Supplier and DME (Part B) claims are available on a quarterly basis and are finalized and closed for a particular service year 18 months following the start of that service year. For example, the CMS 2014 Claims SAFs are finalized and closed in June 2015. This means that for a claim incurred on January 1, 2014, this system allows for an 18-month window for processing; claims incurred in December 2014 have a 6-month window for processing to complete.

The service dates of the claims correspond to the actual dates of service and should be used to determine inclusion in analyses. The calendar year of the SAFs should not be used to determine inclusion in analyses. A small number of claims included in a given year’s file may have service dates that do not correspond to that claim year.

**Patients and Time Periods Included**

The claims database contains data only for Medicare as Primary Payer (MPP) and Medicare as Secondary Payer (MSP) patients, so claims-based analyses, such as analyses of cost and hospitalization, will not include non-Medicare patients. Non-Medicare patients, therefore, must be identified and excluded when determining numbers of patients or patient years at risk for analyses of cost per patient or hospitalization rates. In addition, as it is impossible to determine the complete hospitalization history or complete cost of care for ESRD patients with MSP coverage, such analyses should also exclude patients during the periods when they have this coverage. The Payer History File can be used to make these exclusions.

In addition, the Medicare Claims Files contain data for some patients not included in the SAF.PATIENTS file. When the USRDS database is updated, all claims for all patients who show an indication of having ESRD are retrieved from the CMS database. Some patients are then filtered out and are not included in SAF.PATIENTS or the USRDS analyses. This procedure allows the USRDS Coordinating Center itself to exclude data, rather than request them anew from CMS should they be needed later. Patients may be filtered out because of problems with the data, such as when two patients have the same Medicare ID or Social Security number, or a patient’s listed birth date comes after the death date. In other cases, too little information is available to establish the presence of ESRD or a date of first ESRD service. Sometimes a person filtered out one year passes the filters the next year because data problems are resolved or new data confirm that the patient has ESRD. Researchers need to decide whether to include the claims for these patients in their analyses. The claims can be excluded by merging the claims file with SAF.PATIENTS by USRDS_ID and selecting only patients who appear in SAF.PATIENTS.
The USRDS database also includes pre-ESRD claims for patients who were entitled to Medicare due to age or disability before they developed ESRD. Because these data are not available for all patients, and because it is likely that patients entitled to Medicare before ESRD are systematically different from those not entitled, analyses of these data must be designed with care.

It is important to note that some overlap exists between the pre-ESRD claims datasets prior to 2010 and the ESRD claims datasets prior to 2012, as both claims sets include complete claims information for the calendar year of incidence. Care must be taken to avoid double counting of claims during this time frame. Our recommendation is to search the pre-ESRD claims up to, but not including, first ESRD service date, and the ESRD claims starting at first ESRD service date. To obtain claims from the ESRD period only, merge the claims file with PATIENTS to identify the first service date, and select only those claims occurring on or after this date. It is up to researchers to determine how or whether to include claims that straddle the first service date.

Pre-ESRD Files from claim service year 2010 and after contain only pre-ESRD claims. 2010, 2011, and 2012 pre-ESRD files created as part of 2014 SAF files are based on criteria of clm_from < first_se, 2013 pre-ESRD files created as part of 2015 SAF files are based on criteria of clm_thru < first_se. ESRD files from claim service year 2012 and after contain only ESRD claims (2012 ESRD files created as part of 2014 SAF files are based on criteria of clm_from >= first_se, 2013 ESRD files created as part of 2015 SAF files are based on criteria of clm_thru >= first_se).

**File Structure**

The ESRD claims are organized by claim service year. The majority of records in a particular claim service year file are claims with a service date within that claim service year. For example, in PS2004 (Physician/Supplier records incurred in claim service year 2004) most of the records have a claim from date within calendar year 2004.

**ESRD Institutional Claims File Structure**

Institutional Claims are for hospital inpatient stays, hospital outpatient services, and care provided at dialysis facilities, skilled nursing facilities, home health agencies, and hospices. Institutional Claims are submitted on Part A claims forms, which have a large header portion followed by variable length trailers. Possible trailer fields include diagnoses, procedures, and revenue centers. The header portion is in the “Institutional Claims” File, the trailer fields are in the “Claims Details” File. Starting with calendar year 2008, “Claims Details” are separated into a “Claims Details” File and a “Revenue Center Details” File, with “Claims Details” File for diagnostic and procedural codes, and the “Revenue Center Details” for revenue center details.
Effective on January 1, 2008, CMS required an important change in billing requirements for ESRD facilities. This change in turn had a substantial effect on the content of the Institutional Claims Files that the USRDS receives from CMS for ESRD patients. The USRDS Institutional files for years prior to 2008 will not change, but USRDS Institutional files for calendar year 2008 and later are changed in order to accommodate the changes in the Institutional files obtained from CMS. CMS mandated changes in billing requirements for ESRD facilities for 2008 essentially require ESRD facilities to report each separately billable service (e.g., dialysis, ESA administration) as a separate revenue center line item with a date of service for each service. In the past, ESRD facilities were able to bill an entire month of each separately billable service as a single line item (i.e., one line item for dialysis, one for erythropoietin (EPO), one for IV Iron, etc.). Since January 1, 2008, ESRD facilities are required to report each service separately, so a typical month of dialysis would require 13 separate line items for each session (as opposed to one line item in previous years), 13 separate line items for EPO administrations (instead of one), and so forth. The practical result of this change (which was actually phased in over the entire 2007 calendar year) is an enormous increase in revenue center details records, from 76 million in 2006 to over 175 million in 2008. Meanwhile, the number of other details records showed the usual yearly increases (from 39 million to 43 million over the same time period).

The increased details in ESRD billing may be useful for studying patterns of utilization, so the USRDS will make these additional revenue line items available to researchers. The Revenue Center Details will no longer be included in the Institutional Claims Details File, but rather in a separate Revenue Center Details SAF. CMS also altered the method for ESRD facilities reporting of EPO administration and dosage. These changes are described in the EPO Variables section.

The details can be linked back to the claims. Complete listings of the variables in the Institutional Claims, Claims Details, and Revenue Center Details Files are available in Appendix B: Data File Descriptions. Some variables are also described in Section 5: Contents and Variables. The claims are uniquely identified by a compound key consisting of four variables (USRDS_ID, CLM_FROM, HCFASAF, and SEQ_KEYC), which are used to uniquely link claims records among the Institutional Claims, Claims Details, and Revenue Details Files. The records in all Institutional Files are sorted and indexed by this compound key. The derivation of the dialysis and EPO variables on the Institutional Claims record is described below in Section 5: Contents and Variables.

In 2012 and prior years’ files, each of “Claims” (INC in file name), “Claims Details” (DET in file name) and “Revenue Details” (REV in file name, since 2008 claims) consisted of six types of claims and these six types of claims can be distinguished by the HCFASAF variable, as indicated in Table 18.
Table 18. Claims types in the HCFASAF variable

<table>
<thead>
<tr>
<th>Type</th>
<th>HCFASAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agency</td>
<td>H</td>
</tr>
<tr>
<td>Hospice</td>
<td>S</td>
</tr>
<tr>
<td>Inpatient</td>
<td>I</td>
</tr>
<tr>
<td>Outpatient</td>
<td>O</td>
</tr>
<tr>
<td>Dialysis</td>
<td>D</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>N</td>
</tr>
</tbody>
</table>

DATA STRUCTURE IN THE 2015 SAFS (2013 CLAIMS)

In 2013 Institutional Claims data, three types of files were created for five types of institutional claims services. The three types of files are: “Claims” file (CLM in file name), “Claims Details,” or multiple trailers for diagnoses and procedure details (DXP in file name, previously DET) files, and “Revenue Details,” or multiple trailers for revenue center details (DET in file name, previously REV). The five types of institutional claims services are: Outpatient (OP in file name), Inpatients (IP in file name), Home Health Agency (HH in file name), Hospice (HS in file name) and Skilled Nursing Facility (SN in file name). Therefore, instead of only three ESRD Claims files, 2013 ESRD Claims SAFs include 15 different files. ________________________
Table 6. Relationship of 2013 Institutional Claims dataset with 2012 and prior years’ claims dataset shows the relationship of 2012 and prior year’s files with 2013 files. Dialysis claims (HCFASAF="D" in 2012 and prior years’ files) can be found in the Medicare Claims Clinical data (Claim_clinical), which is described in the What’s New in 2015 section of this guide.

ESRD Physician/Supplier Claims File Structure

Physician/Supplier claims are bills covering physician, laboratory, and radiology services, as well as medical supplies. They account for approximately 80% of the claims but only 20% of the dollars. One diagnostic and one procedural code can occur on each physician/supplier record, which is a line item of the entire claim. One visit to a physician can generate multiple line-item records.

While there are only minor differences in the structure of the data included in the five institutional claims types (hospital inpatient, hospital and freestanding outpatient, hospice, home health agency, skilled nursing facility), the structure of the Physician/Supplier claims is substantially different from that of the Institutional Claims.

Compared to Institutional Claims, Physician/Supplier claims have a simpler header portion and fewer trailer fields, including the revenue center with a CMS Common Procedure Code Standard (HCPCS) procedural code. Unlike the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) procedural codes on the Institutional Claims, which primarily record invasive surgical procedures, HCPCS codes record all procedures performed by physicians (e.g., patient histories) and all supplies, ranging from Band-Aids® to dialysis machines.

Data Structure Prior to the 2014 SAFs (Prior to 2012 Claims)

Prior to the 2014 SAFs (prior to PS2012), the related claim-level and line-item data files for each type were merged together, and then stacked. Multiple trailer records for diagnosis details were also included. (Figure 2).

Figure 2. Physician/Supplier claims file structure (prior to 2012 claim files)

Prior to the 2014 SAFs (prior to PS2012), the related claim-level and line-item data files for each type were merged together, and then stacked. Multiple trailer records for diagnosis details were also included. (Figure 2).

Data Structure in the 2014 SAFs (2012 Claims)

In the 2012 Claims File, the related claim-level and line-item data files for each type were merged together, and then stacked (Figure 3).
For 2013 Physician/Supplier claims, three types of files were created for PS claims (PS in file name) and DME claims (DME in file name): claim-level file (CLM in file name), multiple trailers for line-item details of the claim (LINE in file name), and multiple trailers for diagnoses and procedure details of the claim (DX in file name). Therefore, instead of only one ESRD PS Claims File, 2013 ESRD PS Claims SAFs include six different files. The relationship of 2012 and prior year’s PS claims with 2013 PS claims are listed in Table 7. Relationship of 2013 Physician/Supplier Claims datasets with 2012 and prior years’ claims datasets. The data structure of the 2013 Physician/Supplier Files is also described in the What’s New in 2015 section in this guide.

**Pre-ESRD Claims File Structure**

Pre-ESRD Medicare Institutional Claims and Physician/Supplier Claims are available starting from the 1993 claim service year.

**Data Structure Prior to the 2015 SAFs**

Prior to the 2015 SAFs, the structure of the Pre-ESRD Claims Files is identical to the ESRD Claims Files. Each pre-ESRD claim service year file contains claims for multiple incident years. For example, the claims labeled 2004 contain the pre-ESRD claims for incidents patient in 2004, 2005 and 2006. The claims are NOT constrained to an exact two-year period. Patients who are treated for ESRD for the first time are known as incident ESRD patients. Patients who are incident for ESRD at the end of a calendar year may have claims extending back for nearly three years prior to their incident date.

To obtain a patient’s complete pre-ESRD records, three Pre-ESRD Claims Files should be used. These are the claim service year file that corresponds to the calendar year of incidence for that patient, the claim service year file that corresponds to the incident calendar year minus 1, and the claim service year file that corresponds to the incident calendar year minus 2. For example, to obtain pre-ESRD Physician/Supplier records for a patient incident in 2006, PS2006, PS2005 and PS2004 should all be used (Figure 4).
Figure 4. Example of Pre-ESRD Physician/Supplier Record for an incident ESRD patient in 2006 (files created prior to SAF 2014 have the same structure)

Data Structure in the 2015 SAFs

In the 2015 SAFs, pre-ESRD files are grouped by patients incident in the same year. Files for patients incident in 2011, 2012, and 2013 were created. The data structure is different from prior years’ files. In the 2015 Pre-ESRD SAF Files, the patient cohort is incident patients for an incident year in each file, and each file contains pre-ESRD records from four years of claims files prior to the incident year and pre-ESRD records in incident year claims files, which is a total of five years pre-ESRD records. The 2015 SAF Pre-ESRD files are also described in the What’s New in 2015 section in this guide.

Contents and Variables

Institutional Claims File

The Institutional Claims File has one record per claim, with a claim generally representing a single instance of service, such as a hospital inpatient stay, an outpatient surgery, or a month of dialysis. Dollar values for total charges and payment amounts are stored in the claims file, which also shows the type and number of dialysis sessions included in the claims. Data in the Institutional Claims File allow researchers to determine dialysis treatment modality over time, compute hospitalization rates, and determine aggregate costs by time period and type of cost. These data are sufficient for many research studies and most USRDS products. Analyses of particular diagnoses, procedures, or revenue centers require the claims detail files, which are described in the Institutional Claims Details and Revenue Center Details section. Complete listings of the variables appearing in the Institutional Claims Files are available in Appendix B: Data File Descriptions. Detailed information for some Institutional Claims File variables is provided in the next section.

Medicare Payment Variables

CLM_TOT is the total amount billed for the claim, while CLM_AMT is the amount actually paid by Medicare. For inpatient and skilled nursing facility claims, the cost also includes an amount for the CMS pass-through payments for items such as indirect medical education, capital, and kidney acquisition for transplants. To obtain this pass-through payment amount, multiply the per diem
amount (PER_DIEM) by the count of covered days (CVR_DCNT). In addition to these overall amounts, the billed amount for dialysis and for EPO are provided by the variables DIALCASH and EPOCASH.

**Dialysis Variables**

The variable RXCAT indicates the type of dialysis, if any, included in a claim. RXCAT is derived from DIALREVC and DIALCRC, which come from the Revenue Center and Claim Related Condition details, as described below. The UNITS value from the Revenue Center detail that indicates dialysis is used to calculate the number of dialysis sessions. For in-center hemodialysis, UNITS generally indicates a plausible value for the number of dialysis sessions. For other types of dialysis, particularly CAPD and CCPD, this variable may indicate the number of days. An adjustment is made for CAPD and CCPD to calculate “hemodialysis equivalent” sessions for these modalities. DIALSESS is the resulting number of total dialysis sessions. DIALCASH is REV_CH from the Revenue Center details and is the provider’s billed charge rather than the Medicare payment. The Revenue Center and Claim Related Condition details, which indicate dialysis, are not included in the Institutional Claims Details File prior to 2001. All dialysis revenue line items are included in the Institutional Claims Details File between 2001 and 2007, and are included in the Revenue Center Details File starting with calendar year 2008.

**EPO Variables**

Summary variables are provided for EPO treatments covered by a claim. EPO treatments are identified by Revenue Center codes “0634” and “0635” on a Revenue Center details claim. For claims prior to 2008, the variable for number of EPO administrations (EPOADMIN) is the UNITS variable from the Revenue Center details, while the variable for EPO payments (EPOCASH) is the REV_CH variable. If the claim has multiple Revenue Center details indicating EPO, the EPOADMIN and EPOCASH are summed over these details. The Revenue Center details from which these variables are retained in the Institutional Claims Details SAF starting with CY2001. The variable for the dose of EPO (EPODOSE), prior to 2008 either came from a Claim Related Value detail with code “68”, or had to be calculated by dividing the total payments variable (RPRVPMT) by price per unit for HCPCS codes “J0885”, and “J0886”, and, with the 2012 file, code “Q4081”, which began appearing on bills after 2007. The variable for hematocrit (HCRIT) comes from a Claim Related Value detail with code “48”. The Claim Related Value details from which these variables come are not retained in the Institutional Claims Details SAF. CMS mandated line-item billing for ESRD facilities effective January 1, 2008. Facilities are now required to report each EPO administration as a separate line item, and to report the EPO dose administered in the UNITS field as a multiple of 100 (e.g., a dose of 5,000 units would be reported as 50 in the UNITS field). Value code “68”, the total EPO dose, is no longer required. EPODOSE is created as a composite variable that checks for both the relevant HCPCS and the CRV details and
considers the year in which the bill was incurred to properly handle the UNITS variable. Also starting with the 2008 claims, a summarization of darbepoetin (DPO) claims, identified by HCPCS codes, is also included on the claim.

**Institutional Claims Details and Revenue Center Details**

The Institutional Claims Details File includes a variety of details about each claim. The records in this file can be linked back to the corresponding claim in the claims file. There may be none, one, or many records for each type of detail for a particular claim:

- ICD-9-CM diagnosis codes
- ICD-9-CM procedure codes
- CMS revenue center codes (line item, for years prior to 2008)
- CMS claim related condition codes
- CMS claim related value codes

There can be any number of Institutional Details records for each Institutional Claims record. The Claims Details Files are sorted by the same four-part compound key as the Claims files, so that this key can be used to link the files. The multi-file structure is a solution to the problem of a number of important data items that appear none, one, or many times on a given claim.

Hospital inpatient stay claims, for example, always have DRG codes, but other types of institutional claims never have this code. All claims should have at least one ICD-9-CM diagnosis code, but they may have up to 26. A hospital inpatient claim probably uses one or more ICD-9-CM surgical procedure codes if the stay involved surgery, but may also have revenue center details that specify procedures using HCPCS and/or revenue center codes, and an outpatient claim is more likely to specify procedures using revenue center codes with HCPCS codes. Using a master with a details file creates a simple structure easily manipulated in SAS. Examples of useful value code details (CDTYPE = “V”) are height and weight, which are required elements for ESA and dialysis claims beginning with the 2007 claim set. Code “A8” indicates that the value of the UNITS variable is patient post-dialysis weight (in kilograms), while code “A9” indicates that the UNITS variable holds the patient height (in centimeters). Prior to 2012, for CODETYPE = “V”, only the records with CODE equals “A8”, “A9”, “37”, and “48” were kept in Institutional Claims Details. From 2012 and on, all records for CODETYPE = “V” are kept in Institutional Claims Details. Complete listings of the variables appearing in the Institutional Claims Details Files are available in Appendix B: Data File Descriptions.

The Revenue Center details are the source of a number of important variables. The Revenue Center details correspond to the Revenue Center “trailers” on the CMS SAF records. A record “trailer” is a section of the file record that can appear a variable number of times; the number of occurrences is
indicated by an additional variable resulting in records that vary in length depending upon the amount of data present. The CMS SAF records have nine types of trailers, making the record structure quite complex. The Revenue Center details (or record trailers) provide data about the breakdown of the total charges into charges from “each cost center for which a separate charge is billed (type of accommodation or ancillary).” A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Each Revenue Center detail contains a variable for the amount charged (REV_CH in the Institutional Claims Details File), and one detail, while Revenue Center code “0001”, is the sum of all of the REV_CH for all other Revenue Center details for that claim. To test the consistency of the Revenue Center Details and the CLM_TOT variable, the Coordinating Center examined the original CMS SAF records for 10,000 inpatient and 10,000 outpatient claims. In all cases, the ‘0001’ Revenue Center amount was the sum of the other Revenue Center amounts. In about 3% of the inpatient records, however, CLM_TOT was greater than this sum. Beginning in late 2000, CMS began providing a field in the revenue trailers called revenue center payment amount, which corresponds to the payment amount for each revenue center trailer for all outpatient claims. This field is included as an additional variable (REVPMT) in the Institutional Details SAF, starting with calendar year 2001. This value allows researchers to more accurately determine the payment amount for individual types of Revenue Center services (such as laboratory service, EPO, and dialysis) billed on outpatient claims. One caveat for using this variable is that the REVPMT summed overall Revenue Center Details for a given claim will not always agree with the CLM_AMT variable contained in the Institutional Claims SAF for that claim. Our analysis showed that the sum of REVPMT over all outpatient claims exceeded the CLM_AMT for all outpatient claims by approximately 3%. The SAS format $REVCEN gives labels for the Revenue Center codes (the CODE variable on records with CDTYPE = “R”). The Revenue Center Details are the source for the dialysis and EPO variables on the Institutional Claims File. Codes “0800-0809” and “0820-0889” indicate the type of dialysis (DIALREVC). UNITS provides the number of dialysis sessions (DIALSESS), and REV_CH provides the dialysis charges (DIALCASH).

DIALCASH should be treated with caution because its use may be inconsistently defined; it is not clear if the value is the charged amount or the CMS allowed charge, and definition of the value may vary from institution to institution. When a claim has only one dialysis Revenue Center code, as is usually the case for years prior to 2001, a Revenue Center Details record is not produced because the relevant data items are recorded on the Institutional Claims record. If a claim has multiple Revenue Center Details indicating dialysis, the dialysis variables are derived from the first Revenue Center code encountered, giving precedence to the more specific codes. In this case, a detail record is created for each Revenue Center detail on the claim so users have the opportunity to interpret the
multiple details. Other Institutional Revenue Center details are of lesser interest unless a HCPCS code is included indicating a more specific service. A code showing that a claim is for laboratory services, for example, frequently includes a HCPCS code indicating the specific test performed. Revenue Center Details records are included regardless of the presence or absence of a HCPCS code. Before calendar year 2008, Revenue Center Details records were included with other Claim Details records, and after 2008 were placed in a separate file. For many analyses, the Revenue Center Details records may not be required. Complete listings of the variables appearing in the Revenue Center Details Files are available in Appendix B: Data File Descriptions. The detailed information for some Revenue Center Details File variables are described in the next section.

**CDTYPE and CODE Variables**

The variable CDTYPE indicates the type of code contained in the CODE variable (e.g., a diagnosis code, a procedure code, a revenue center code, etc.). For instance, a code of “I” in the CDTYPE variable indicates that the value of the CODE variable is ICD-9 diagnosis code; a code of “P” in the CDTYPE variable indicates that the value of the CODE variable is an ICD-9 procedure code. Both variables are present on every record, but the variables UNITS, REV_CH, HCPCS, and URR_CD are not present for some CDTYPEs. The SAS format $CDTYPEI indicates the meaning of each CDTYPE.

**UNITS**

Use of the UNITS variable varies with CDTYPE. When CDTYPE = “P” (ICD-9-CM Surgical Procedures), UNITS is a value created by the USRDS to indicate when the surgical procedure was performed, and time is expressed as the number of days from the date given by CLM_FROM, with CLM_FROM counted as 1. A value of 1 for UNITS indicates that the procedure was performed on the date given by CLM_FROM, and 2 indicates the day after CLM_FROM. When CDTYPE = “R”, UNITS is described in the CMS file documentation as “a quantitative measure (unit) of services provided to a beneficiary associated with accommodation and ancillary revenue centers”. From 2008, CDTYPE = “R” records are all in Revenue Center Details File. Depending on the type of service, units are measured by number of covered days in a particular accommodation, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests. The revenue center code or the HCPCS code indicates the type of service. Because the meaning of UNITS varies greatly, the variable must be used with caution. When using this variable, tabulate the distribution of values over the records being analyzed to ensure that the values look correct. When CDTYPE=“I”, UNITS has a value of 1 or 0, where 1 indicates that this was the primary diagnosis for this claim and 0 indicates that it was a secondary diagnosis. The claim details are not necessarily sorted with the primary diagnosis first.
REV_CH

REV_CH occurs only on Revenue Center details records (CDTYPE=“R”) and indicates “the total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and co-insurance amounts and before an adjustment for the cost of services provided.” REV_CH corresponds in concept to the CLM_TOT variable on the Institutional Claims File, as discussed above under Revenue Center Details.

HCPCS and MOD1-MOD5

The CMS Common Procedure Coding Standard (HCPCS) “is a collection of codes that represent procedures, supplies, products, and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs.” In Institutional Claims Files, the HCPCS code occurs only on Revenue Center (CDTYPE = “R”) details, but may not be present on all such records. HCPCS are an extension of the American Medical Association CPT-4 codes, and CPT-4 codes can only be found in HCPCS in Revenue Center Details Files. Codes for certain pharmaceuticals, laboratory procedures, durable medical equipment, and radiology procedures are added to the CPT-4 codes to form HCPCS. Starting with calendar year 2010, the HCPCS code may be accompanied by up to five HCPCS modifier codes (MOD1-MOD5). These modifiers are used to report information related to the services described by the HCPCS code. For example, beginning July 1, 2010, CMS requires the use of the modifiers V5 (catheter), V6 (graft), and V7 (fistula) to report the type of vascular access in use, and V8 (infection) and V9 (no infection) to report absence or presence of access infection on the last dialysis line item of each dialysis bill. Another example would be modifiers for IV (JA) and subcutaneous (JB) administration of ESA.

URR_CD

Starting in 1998, CMS began requiring the reporting of Urea Reduction Ratios (URRs) on outpatient hemodialysis claims. The URR is reported as a range that reflects the results for the month being billed. This information appeared as a formatted value in the Revenue Center Details for hemodialysis claims in 2012 and prior years’ files. In 2013 files, URR_CD is in the “Claims” file.

Physician/Supplier Claims

In the Physician/Supplier File, a claim does not necessarily correspond to a logical instance of service, but is more likely to represent all services provided to a patient during the provider’s billing period. In 2012 and prior years’ files, the file is constructed as a line item file, with one record per claim line item. For physician claims, the from/through dates can be used to identify a series of line items associated with a single visit. For supplier claims, however, the instance of service is more difficult to define. Bills
for home dialysis dialysate, for example, specify the quantity and delivery date of the dialysate but not the time period over which it is to be dispensed. Claims and line records are in separate files in the 2013 files.

**CLMTYP**

In 2012, the CLMTYP variable, which indicates whether the record comes from physician/supplier claims or durable medical equipment claims, was added to Physician/Supplier Claims Files. CLMTYP = “P” indicates a physician/supplier claim; CLMTYP = “D” indicates a durable medical equipment claim. Claims may or may not have supporting line item data; notably, payment variables for records with no line item data will be missing. CLMTYP is kept in 2013 files, even though Physician/Supplier Claims and Durable Medical Equipment Claims are in separate files and can be distinguished by the file names.

**CDTYPE and DIAG**

Prior to 2012 files, claims and line records were stacked. Claims and line records have a one-to-many relationship, meaning there is one claims record to one or more line records. CDTYPE = “B” indicates a physician/supplier line item and the DIAG variable indicates the diagnosis code associated with this line item. CDTYPE = “I” indicates that this record is a claim record and the DIAG variable indicates primary diagnosis. This primary diagnosis code exists in the DIAG variable in one of the corresponding line records. That means that if one is interested in analyzing the DIAG values in files prior to 2012, depending on purpose of analysis, one will need to separate CDTYPE=”B” and CDTYPE=”I” records, or there is a real chance of code values being counted more than once.

In 2012 files, claim and line records were merged and the CDTYPE variable is dropped. The DIAG variable is populated with line record diagnosis codes if the line record diagnosis value was not missing; otherwise, it was populated with the claim-level primary diagnosis code. In 2012, there is no risk of unintentionally double counting DIAG codes. In 2013 files, claims and line records are in separate files and the DIAG variable is kept in both the claims file and the line file.

**HCPCS and MOD1-MOD4**

HCPCS in Physician/Supplier Claims contain procedure codes, as described in the “HCPCS and MOD1-MOD5” section in *Institutional Claims Details and Revenue Center Details*. Variables MOD1-MOD4 are included to further identify the type of service billed on the line item. They are used in conjunction with the HCPCS/CPT code on the line item, and their meaning can be found in the Current Procedural Terminology codebook and the HCPCS Level II codebook.
The Physician/Supplier specialty code (SPCLTY) can be useful for untangling the bills for a specific surgical procedure. The principal surgeon, physician surgical assistants, and anesthesiologist use the HCPCS referring to the major invasive surgery to bill for that surgery. The code for nephrologists is “39”.

The place of service variable (PLCSRVR) indicates where the service was rendered. It can be used to distinguish between inpatient and outpatient services and between home dialysis and in-unit dialysis supplies. The value “6” refers to an ESRD treatment center.

The CMS service code variable (HCSRVC) can be used to distinguish between the principal surgeon and assistants. The value for immunosuppressive drugs is G, for renal supplier in the home L, for monthly capitation payment (dialysis) M, and for kidney donor N.

Three payment fields appear on each Physician/Supplier line item: submitted charges (SBMTCH); allowed charges (ALOWCH), which are the lower of prevailing, customary, or actual as determined by CMS; and the payment amount (PMTAMT), the amount paid to the provider and/or beneficiary after deductible and co-insurance amounts have been paid for the services included as a line item on a physician/supplier claim (a complete listing of the variables in the Physician/Supplier Claims Files is available in Appendix B: Data File Descriptions).

After the implementation of the bundled payment system in 2011, approximately 15% fewer physician/supplier claims were submitted to CMS. We believe this is because the implementation of bundled care changed the way in which health care providers applied for Medicare reimbursement for ESRD patient care. Specifically, a given patient’s dialysis facility now submits claims for any bundled care, even if it is performed by an outside physician. In turn, the facility reimburses the provider for any bundled care provided to the ESRD patient. Therefore, when looking at temporal trends in payment data, for example, researchers will see a decline in payments after January 2011. In addition, when looking at trends that cross the bundle implementation date, it is necessary to restrict payment analyses to care that falls outside of the bundle. Researchers may use the list of bundle-covered medication and laboratory procedures at the Medicare website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html.
### Section 6: Transplant Process and Outcomes

Transplant patients constitute a unique subset of the ESRD population and are often studied separately from dialysis patients. Researchers may wish to simply count the number of transplant events that meet certain criteria, or calculate transplant event rates and survival probabilities. Using the USRDS transplant data, researchers can obtain information on transplant events, such as donor and recipient characteristics, and on patient- and graft-related outcomes.

### Data Sources

Basic transplant variables are contained in the Transplant File in the Core SAF. Transplant event data are combined from CMS and OPTN databases. Before 1988, CMS was the primary source for all transplant event data. Between 1988 and 1993, both CMS and OPTN collected information regarding transplant events. Since 1994, OPTN has been the primary source for all transplant event data (Figure 5).

#### Figure 5. Source of transplant events in the USRDS population

<table>
<thead>
<tr>
<th>Year</th>
<th>Source of Transplant Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>All transplants from CMS data are accepted</td>
</tr>
<tr>
<td>1988</td>
<td>All transplants from OPTN data are accepted. Transplants from CMS data are accepted if they occur at least 30 days either side of an event found in OPTN data.</td>
</tr>
<tr>
<td>1994</td>
<td>All transplants from OPTN data are accepted.</td>
</tr>
</tbody>
</table>

### Reconciliation of CMS and OPTN Events

The USRDS has implemented a decision algorithm, described in detail in Section 2: ESRD Patients, which reconciles identical transplant events when multiple sources contain conflicting information. Each transplant event found in the Transplant File (TX) of the Core SAF dataset is thus a unique event that the USRDS believes occurred after reviewing both OPTN and CMS REMIS Transplant and Medical Evidence record files. Table 19 details the various USRDS SAFs related to transplant. The
Transplant File (TX) in the Core SAF contains transplant dates, basic descriptive data, and causes of graft failure, when known.
### Table 19. USRDS Transplant files

<table>
<thead>
<tr>
<th>File</th>
<th>Data Source</th>
<th>Comments</th>
<th>Years</th>
<th>Dataset</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Constructed by USRDS Coordinating Center from OPTN, CMS PMMIS/REBUS, Transplant, Medical Evidence Files</td>
<td>Identifying data on all known transplants</td>
<td>All 3/9/1963+</td>
<td>Core</td>
</tr>
<tr>
<td>WAITLIST_KI</td>
<td>OPTN Transplant Waiting List File</td>
<td>Contains data of patients on kidney waiting list per listing event</td>
<td>Listing date 3/1/1970+</td>
<td>Core</td>
</tr>
<tr>
<td>WAITSEQ_KI</td>
<td>OPTN Transplant Waiting List File</td>
<td>Contains condensed, center-specific, kidney waiting list dates</td>
<td>Listing date 3/1/1970+</td>
<td>Core</td>
</tr>
<tr>
<td>WAITLIST_KP</td>
<td>OPTN Transplant Waiting List File</td>
<td>Contains data of patients on kidney-pancreas waiting list per listing event</td>
<td>Listing date 9/2/1986+</td>
<td>Core</td>
</tr>
<tr>
<td>WAITSEQ_KP</td>
<td>OPTN Transplant Waiting List File</td>
<td>Contains condensed, center-specific, kidney-pancreas waiting list dates</td>
<td>Listing date 9/2/1986+</td>
<td>Core</td>
</tr>
<tr>
<td>TXHCFA</td>
<td>CMS PMMIS/REBUS Transplant File</td>
<td>Details from CMS</td>
<td>1976-93</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXUNOS_KI_PRE_JUL04</td>
<td>OPTN Candidates, Recipients, Donors, Histocompatibility Files</td>
<td>Contains kidney recipients transplant details</td>
<td>Transplant date 10/1/1987-6/29/2004</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXUNOS_KI_POST_JUL04</td>
<td>OPTN Candidates, Recipients, Donors, Histocompatibility Files</td>
<td>Contains kidney recipients transplant details</td>
<td>Transplant date 6/30/2004+</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXUNOS_KP</td>
<td>OPTN Candidates, Recipients, Donors, Histocompatibility Files</td>
<td>Contains kidney-pancreas recipients transplant details</td>
<td>Transplant date 10/15/1987+</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXFUHCFA</td>
<td>CMS PMMIS/REBUS Transplant Follow-Up File</td>
<td>Follow-up details, CMS</td>
<td>1988+</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXFUUNOS_KI</td>
<td>OPTN Kidney Recipients Follow-Up File</td>
<td>Contains kidney recipients transplant follow-up details</td>
<td>Transplant date 1/1/1988+</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXFUUNOS_KP</td>
<td>OPTN Kidney-pancreas Recipients Follow-Up File</td>
<td>Contains kidney-pancreas recipients transplant follow-up details</td>
<td>Transplant date 1/5/1988+</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXIRUNOS</td>
<td>OPTN Immunosuppression at Time Of Transplant</td>
<td>Immunosuppression details for kidney and kidney-pancreas recipients at the time of transplant</td>
<td>Transplant date 1/1/1988+</td>
<td>Transplant</td>
</tr>
<tr>
<td>TXIFUNOS</td>
<td>OPTN Immunosuppression at Follow-Up</td>
<td>Immunosuppression details for kidney and kidney-pancreas recipients at follow-up</td>
<td>Transplant date 1/1/1988+</td>
<td>Transplant</td>
</tr>
</tbody>
</table>

### Kidney and Pancreas Waiting list

The Core SAF also contains four files with information on the kidney and simultaneous kidney-pancreas waiting list files from OPTN. Most investigators are simply interested in the dates of listing at specific transplant centers. The WAITSEQ_KI and WAITSEQ_KP Files contain entry and removal date sequences per patient per transplant center for the kidney alone and simultaneous kidney-pancreas waiting lists, respectively. These records are collapsed from the raw OPTN Waiting List Files WAITLIST_KI and WAITLIST_KP. Both the raw OPTN Waiting List Files and the Sequence Files
contain two patient identifiers, PID and USRDS_ID. ESRD patients included in the USRDS patient profile have a USRDS_ID.

Because the Sequence Files are collapsed versions of the Waiting List Files, investigators should use caution when linking back to the raw waiting list files to obtain information such as Panel Reactive Antibody (PRA) values. Investigators will need to obtain all raw waiting list records and then make decisions as to which record contains the information most relevant to their needs. Some specific assumptions the USRDS Coordinating Center used to collapse waiting list records are as follows:

- Candidates listed in error were removed (REMCODE = 10).
- Patients with missing listing dates (EDATE = .) were removed.
- Patients with listing and removal dates on the same date were removed.
- Transplant dates were taken from the USRDS.
- Transplant File and not from the OPTN Waiting List File.
- The transplant dates on the USRDS Transplant File are cleaned and reconciled with other sources of data, so these dates were used to ensure consistency. In the event that a patient not known to the USRDS received a transplant, the OPTN transplant date found in the raw Waiting List File was used.
- Known transplant dates are used to truncate waiting periods at all centers at which a patient is currently listed. For example, if a patient underwent transplant but was not removed from a center's waiting list, a removal date would be imputed on the transplant date. This is true for all centers at which a patient is listed.
- Patients with inactive waiting periods were removed; the waiting list sequence lists only active periods.
- Overlapping waiting periods at the same center were collapsed.

**Transplant SAF**

To obtain additional data regarding transplant events, users need the Transplant SAF, which contains detailed information, in separate files, from CMS and OPTN (UNOS). The Transplant File in the Core SAF contains reconciled transplant event data from all available sources. As some researchers may find it beneficial to see the transplant data obtained from each source, data from each source are included.

Two Transplant Files contain data collected by CMS and OPTN (UNOS) on transplant follow-up visits. The follow-up records in TXFUHCFA and TXFUUNOS overlap in time, specifically 1988 to 1993, and contain information collected during patient follow-up visits, which typically occur at 6 months, 1 year, and yearly thereafter. The TXIRUNOS and TXIFUNOS Files contain information on
immunosuppression treatment. Data in these files are from the Kidney Transplant Recipient Registration Worksheet and Kidney Transplant Recipient Follow-Up Worksheet. TXIRUNOS contains data on treatments at the time of transplant, and TXIFUNOS contains data on treatments updated at each follow-up visit, if available. The TXUNOS_KI_PRE_JUL04 and TXUNOS_KI_POST_JUL04 Files now include only kidney (KI) data. In prior SAFs, the TXUNOS_KI_PRE_JUL04 File included both kidney and kidney-pancreas (KP) data. TXUNOS_KP includes all years' kidney-pancreas data. Each file on the Transplant dataset should be considered a separate analytical file. Attempting to combine information from various files involves reconciling information across files.

Starting in 2003, OPTN began to use the bitmask technique to maintain multiple values (i.e., selections/choices) within one variable. This method applies to all multiple selection questions. Previously, OPTN used as many variables as needed to collect all possible answers for such questions. For example, for the question “Treatment: Other therapies,” OPTN used three variables, PHOTOPH, PLASMA and LYMPHOID with answers “Yes/No.” After 2003, OPTN combined these variables into a single variable, THERAPIES, for the same question, using the bitmask technique. The basic code values are as follows: “1” = Photopheresis; “2” = Plasmapheresis; “4” = Total Lymphoid Irradiation (TLI), while “3” represents the sum of values 1 and 2; and “5” indicates that both 1 and 4 are selected. To assist researchers in decrypting these multiple-selection value variables, USRDS has identified all possible additive combinations of these bitmask-value variables and made them available as SAS formats.

Appendix D: Data Collection Forms lists the CMS and OPTN data collection forms, which are available at www.usrds.org. As a cross-reference between the data file and the form, the SAS variable labels (shown in Appendix B: Data File Descriptions) indicate, whenever possible, the question number from the form. The label PM7694, for example, indicates that the variable can be found on the PMMIS from 1976 to 1994. If the question number on the form did not change over time, this number is also indicated in the label. PM819421b indicates question 21b on the PMMIS form collected between 1981 and 1994. Table 20 provides details regarding these labels.
Table 20. Variable label prefixes for Transplant SAFs

<table>
<thead>
<tr>
<th>File</th>
<th>Variable label prefix</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>TXHCFA</td>
<td>PM7681</td>
<td>From CMS form, 1976-1981</td>
</tr>
<tr>
<td></td>
<td>PM8194</td>
<td>From CMS form, 1981-1994</td>
</tr>
<tr>
<td></td>
<td>PM7694</td>
<td>Appears on all CMS forms, 1976-1994</td>
</tr>
<tr>
<td></td>
<td>PM819421b</td>
<td>CMS form, 1981-1994, question 21b</td>
</tr>
<tr>
<td>TXUNOS*</td>
<td>TCR</td>
<td>Transplant candidate registration</td>
</tr>
<tr>
<td></td>
<td>CDR</td>
<td>Deceased donor registration</td>
</tr>
<tr>
<td></td>
<td>LDR</td>
<td>Living donor registration</td>
</tr>
<tr>
<td></td>
<td>DHS</td>
<td>Donor histocompatibility</td>
</tr>
<tr>
<td></td>
<td>RHS</td>
<td>Recipient histocompatibility</td>
</tr>
<tr>
<td></td>
<td>KIR</td>
<td>Kidney transplant recipient registration</td>
</tr>
<tr>
<td></td>
<td>KPR</td>
<td>Kidney-pancreas transplant recipient registration</td>
</tr>
<tr>
<td>TXFUHCFA</td>
<td>TFU</td>
<td>From CMS form before 1994</td>
</tr>
<tr>
<td>TXFUUOS**</td>
<td>KIF</td>
<td>Kidney transplant recipient follow-up</td>
</tr>
<tr>
<td></td>
<td>KPF</td>
<td>Kidney-pancreas transplant recipient follow-up</td>
</tr>
</tbody>
</table>

* Including TXUNOS_KI_PRE_JUL04; TXUNOS_KI_POST_JULY04, and TXUNOS_KP.
** Including TXFUUNOS_KI and TXFUIUNOS_KP.

Most descriptive data on transplant events can be found in the Core SAF Transplant File, which can be used to construct counts of various transplant-related events. Transplant rates can be constructed by combining transplant data with a patient treatment history file, RXHIST or RXHIST60; rates in the ADR are typically calculated using RXHIST60, the treatment history file with the 60-day rule built in. Transplant survival, both graft and patient, can be calculated using the transplant failure date found in the Transplant File and the date of death found in the PATIENTS File.

Section 7: Morbidity and Hospitalization

Morbidity associated with ESRD can be determined from information on hospitalizations and acute events, documented in Medicare claims files through ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) and CPT (Current Procedural Terminology) codes. The USRDS provides data on inpatient admissions, discharges, and diagnosis and procedure codes, which may be used to produce different types of hospitalization rates, such as total admission rates and hospital day rates.
Data Sources

Inpatient hospitalization data, a subset of the data in the Institutional Claims File, are included in the Hospitalization SAFs. These data originate from the Part A institutional inpatient claims data. The patient treatment history file (RXHIST or RXHIST60) provides the patient modality treatment history, which may be used to construct hospitalization rate data, while demographic data are obtained from the PATIENTS File.

Contents of the Hospital Dataset

A complete list of variables in the HOSP dataset can be found in Appendix B: Data File Descriptions. The following list outlines some of the key variables:

- **HCFASAF** indicates the data source of the claim.
- **CLM_FROM** provides the from date of service, indicating the admission date.
- **CLM_THRU** provides the through date of service, indicating the date of discharge.
- **HSDIAG1-HSDIAG26** provide up to 10 ICD-9-CM diagnosis codes in HOSP_to2009; and up to 26 ICD-9-CM diagnosis codes in HOSP_2010on.
- **HSSURG1-HSSURG25** provide up to 10 ICD-9-CM procedure codes in HOSP_to2009; and up to 25 ICD-9-CM procedure codes in HOSP_2010on.
- **DRG_CD** provides diagnostic-related group (DRG) codes, which categorize inpatient stays by ICD-9-CM diagnosis and procedure codes.
- **PRIMDIAG**: equals “yes” when HSDIAG1 provides the primary diagnosis code in HOSP_to2009; and equals primary diagnosis code in HOSP_2010on

Preparing Inpatient Claims Data for Use

Preparing data for analyses requires that they be cleaned, with overlapping hospitalizations for the same patient combined. For the USRDS ADR, the principal diagnosis and procedure codes from the first of two overlapping hospitalizations are retained, with the combined hospitalization extending from the first admission date to the last discharge date.

To create a dataset to calculate rates for period prevalent patient cohorts, attach data for hospitalizations occurring during the selected year by patient USRDS_ID to a period prevalent cohort file for the year. In this way, all patients in the file, including those with multiple hospitalizations and those with none, are included in the rate calculation.
Because hospitalization data are incomplete for non-Medicare patients and for patients classified as MSP, these patients should generally be excluded, thereby limiting their contribution to patient years at risk. The Payer History File in the Core SAF can be used to do this. Another method of MSP patient exclusion involves excluding dialysis patients who do not reach a certain level of Medicare paid dialysis bills. For instance, dialysis patient start dates can be required to fall between start and end dates based on Medicare paid dialysis claims as follows:

- Claims start date: the first day of the first month in which there is at least $675 of Medicare paid dialysis claims.
- Claims end date: the end of a three-month period in which there is less than $675 of paid claims in each month.

If a patient’s start date does not fall between the claims start and end dates, that patient is excluded from the analysis for that year. To calculate rates by patient characteristics, demographic data may be attached to the dataset by patient USRDS_ID from the PATIENTS File.

**Section 8: Survival and Mortality**

Survival and mortality analyses are often used to compare outcomes among treatment modalities, age groups, or races, or to evaluate outcome trends over time. Primary analyses include unadjusted survival probabilities using the Kaplan-Meier method, adjusted survival probabilities using the Cox regression model, unadjusted death rates, and adjusted death rates.

**Data Sources**

Survival and mortality analyses often require patient demographic information such as age, sex, race, primary cause of ESRD, death date, cause of death, and treatment modality history data, which can be obtained from the USRDS Core SAF Files PATIENTS and RXHIST or RXHIST60.

**Section 9: Providers**

The Facility SAF File is constructed from data supplied by the CMS Annual Facility Survey, CDC National Surveillance of Dialysis-Associated Diseases, CMS Dialysis Facility Compare, and CMS CROWNWeb. Data in the Facility SAF are at the facility level and there are no patient-level data. Over time, facilities may be purchased and sold. Thus, a facility may have the same provider number for several years, then be purchased by a different owner and receive a new provider number. The physical facility and location may be the same, and most staff may remain, but the provider number has changed.
The Facility SAF File contains over 100 provider characteristics, including:

- Transplant counts
- Self-dialysis information
- HD, IPD, CAPD, and CCPD patient counts
- Number of in-center new dialysis patients at a facility
- Profit status, and hospital-based or freestanding status
- Chain affiliation
- Reuse practices

**Data Sources**

The CMS Annual Facility Survey is obtained as part of the CROWN data that the USRDS receives. The CMS Dialysis Facility Compare data are received quarterly from CMS. The CDC National Surveillance of Dialysis-Associated Diseases survey was obtained from the CDC annually through 2002. As the last CDC National Surveillance survey occurred in 2002, all data for CDC variables are missing after 2002. A list of the CMS and CDC surveys can be found in Appendix D: Data Collection Forms. Those forms are also available at [www.usrsds.org](http://www.usrsds.org).

**Provider Numbers Assigned by the USRDS**

Each provider has been assigned an identification number by CMS. However, in an effort to ensure confidentiality and conceal provider identity, the USRDS assigned an anonymous number to each provider; these are not the original provider numbers assigned by CMS. Each provider maintains its USRDS-assigned facility ID throughout the SAFs to allow linkage.

Researchers who wish to conduct patient-level studies incorporating the Facility SAF data can link patient information from the Detailed Treatment History SAF (RXHIST), the Condensed Treatment History SAF (RXHIST60), or other SAFs, to the Facility SAF via the USRDS provider number and year. However, investigators are cautioned that analysis of small samples does pose risk of inadvertent patient identification, thus reporting is limited to patient groups (cells) of 11 or greater, per CMS policy.

**Profit Status**

The profit variable, NU_P_NP, has the following values, “For-profit”, “Non-profit”, and “Unknown” (case sensitive). The For-profit group consists of facilities categorized on the CMS survey as individual-
profit, partnership-profit, corporation-profit, or other-profit. Non-profit facilities include individual-non-profit, partnership-nonprofit, corporate-nonprofit, other-nonprofit, state-government non-federal, county-government non-federal, city government non-federal, city/community-government non-federal, hospital district/authority government non-federal, other-government non-federal, Veterans Administration Government Federal, Public Health Service Government Federal, military-government federal, or other-government federal. Those 18 categories are designated by the variable TYPOWNER. However, the 2002 CMS survey dropped this variable and it is missing in subsequent survey periods. Profit status is now determined solely from the CMS Dialysis Facility Compare data.

**Chain Affiliation**

Originally, the USRDS definition of a chain was 20 or more facilities in two or more states owned by the same corporation. The number of chains can vary from year to year depending on changes of facility ownership and the opening of new facilities. Because of the many changes occurring with regard to facility ownership, the original chain definition was modified. Starting with the 2005 facility survey, chains were further classified into Large Dialysis Organizations (LDOs) and Small Dialysis Organizations (SDOs). SDOs are defined as those dialysis organizations that operate at least 20 but not more than 199 facilities. LDOs are those organizations with 200 or more facilities. The chain variable, CHAIN_ID, contains a text string identifying the chain ownership of the facility. A blank value for CHAIN_ID indicates that the facility has no chain affiliation. Facilities with no chain affiliation are divided into hospital-based facilities and independent facilities.

**Freestanding vs. Hospital-based Facility**

A hospital-based dialysis facility is associated with a hospital; it can be located in the hospital or at a remote location. Freestanding dialysis facilities operate independently of a hospital. A study analyzing freestanding vs. hospital-based units will generally include three groups: freestanding, hospital-based, and unknown. The variable NU_HBFS designates this status. A code of “1” represents hospital-based unit, and “2” represents free-standing. The unknown category will consist of any provider in the researcher’s study not found in the Facility database.

**Section 10: CKD Cohort (5% CKD Cohort Dataset)**

Traditionally, the USRDS has focused on the final stages of kidney disease, due to the comprehensive data available from Medicare on all patients with ESRD. However, there is no similar national reporting system for patients with kidney disease prior to end stage. For several years, the USRDS has been
reporting on chronic kidney disease in Volume 1 of the USRDS ADR and making standard analytic files available using a cohort of patients diagnosed with CKD from the Medicare 5% database.

**Data Sources**

To create the CKD cohort dataset by year, the USRDS Coordinating Center uses 5% General Medicare Claims data (1992–2013) and patient demographic information. The CKD cohort dataset contains three basic data components: Patient Master File, Payer Sequence File, and a series of Co-Morbid Files. Below is a description of how the CKD cohort dataset was created using the 5% General Medicare Claims data and the underlying data structure and file organization.

**Patient Master File**

For patients in this file, at least one CKD ICD-9 diagnosis code (Table 21) was identified in the 5% IP, OP, HH, HS, SNF, and PB SAFs, with one record per patient. The two key variables CKD_xx (1-year entry period CKD indicator) and CKD_xyyy (2-year entry period CKD indicator) are defined as follows:

CKD_xx = Y if a patient in year xx (e.g., CKD_95 or CKD_02):

- Was Part A and Part B entitled and not enrolled in an HMO for the entire year (i.e., Payer_Seq_File)
- Had any one CKD ICD-9 diagnosis code from IP or HH or SNF, or any two CKD ICD-9 diagnosis code combinations from PB or OP with different claim dates

CKD_xx = N otherwise

CKD_xyyy = Y if a patient in a two-year entry period (e.g., CKD_9596, CKD_9900, or CKD_0102):

- Was Part A and Part B entitled and not enrolled in an HMO for the entire two-year entry period (i.e., Payer_Seq_File)
- Was alive and did not develop ESRD as of December 31 of the two-year entry period
- Had any one CKD ICD-9 diagnosis code from IP or HH or SNF, or any two CKD ICD-9 diagnosis code combinations from PB or OP with different claim dates identified at any time during the two-year entry period (either in one of the two years or across the two years)

CKD_xyyy = N otherwise

Patients with CKD_95 = Y are a subset of patients in the 1995 Co-Morbid File (Co_Morbid_95) in the Co-Morbid Files dataset; patients with CKD_9900 = Y are a subset of the patients from the 1999 and 2000 Co-Morbid Files (Co_Morbid_99 and Co_Morbid_00) in the Co-Morbid Files dataset, respectively.
Some patients in the Patient Master File may have all CKD_xx = N and all CKD_xxyy = N. This implies that these patients had at least one CKD ICD-9 diagnosis code identified in the 1992 to 2010 5% IP, OP, HH, HS, SNF, and PB SAFs but did not meet the one-year entry period and two-year entry period CKD eligibility criteria described above.

Each patient is identified by two patient identification numbers. One is FIVEP_ID, a unique patient ID in the 5% Medicare sample population and the primary linking key within the USRDS CKD Cohort Finder dataset. Each year, new FIVEP_ID numbers are generated only for new patients added to the 5% sample. All existing patients (repeated patients) are referenced with their previously assigned numbers. A second patient identification number, USRDS_ID, is the unique ID in the USRDS database system for identifying ESRD patients. Only patients with ESRD are assigned a valid USRDS_ID number. FIVEP_ID and USRDS_ID are not related.

**Payer Sequence File**

This file was created from the 5% Medicare denominator files and the IP, OP, HH, HS, SNF and PB SAFs. It contains Medicare coverage information for 5% patients with at least 1 CKD ICD-9 diagnosis code identified through the 5% IP, OP, HH, HS, SNF, and PB SAFs. A patient might have one or many sequence records in which each record indicates different insurance coverage within a well-defined time period. There are five unique insurance types:

- A: Entitled with Part A only
- B: Entitled with Part B only
- AB: Entitled with Part A and Part B
- H: Enrolled in a Medicare HMO health plan
- N: Non-Medicare

The first record contains the earliest available date for coverage information in the 5% Medicare denominator files. The last record contains the last known available date (i.e., the most recent) for coverage information in the 5% Medicare denominator files. FIVEP_ID is the primary patient identification number.

**Co-Morbid Files**

The Co-Morbid Files are constructed from the 5% Medicare IP, OP, HH, HS, SNF, and PB SAFs and named individually by the respective calendar years. Each file contains all patients whose CKD diagnosis was identified from the 5% Medicare IP, OP, HH, HS, SNF, and PB SAFs within that year (i.e., Co_Morbid_95 contains all patients whose CKD disease events were identified from the 1995 5%
Medicare Claims SAFs). However, patients were not necessarily required to be entitled to Parts A and B and not enrolled in an HMO for that entire year. A patient might have one or many records within a calendar year in which each record depicts one unique CKD disease event. Records are considered duplicates if they are extracted from the same type of claim file with the same ICD-9 diagnosis code on the same date. These files do not include duplicates.

For example, each record in Co-Morbid_95 consists of one CKD code per claim file per service date per unique patient in 1995. The combination of claim type, CKD code, and service date for a patient establishes uniqueness in each Co-Morbid File. FIVEP_ID is the primary patient identification number.

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Diagnosis codes</th>
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<tr>
<td>CKD</td>
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<tr>
<td></td>
<td>753.12-753.17, 753.19, 753.2, 794.4</td>
</tr>
</tbody>
</table>

**Section 11: Comprehensive Dialysis Study SAF**

The Comprehensive Dialysis Study (CDS) collected data on patient demographics, contact information, treatment, laboratory values, quality of life (QOL) survey interviews, and nutrition survey interviews for U.S. dialysis patients who started treatment during 2005–2007 at 335 randomly selected dialysis facilities. Patients were selected via a monthly REMIS/SIMS database custom extract process using the following criteria:

- Incident dialysis patients (age ≥ 18) who had survived for at least two months
- No prior transplant
- Dialyzed at one of the pre-determined 335 facilities

Over a period of two years, 11,292 patients were selected. Of these, 1,678 consented and participated in the surveys and/or lab assays. The CDS SAF contains the data for these patients. Of the 1,678 patients, 1,279 participated only in the QOL survey; 364 participated in the QOL and nutrition surveys and/or lab assays (227 with QOL, lab, and nutrition; 4 with QOL and lab; and 133 with QOL and nutrition); 35 did not participate in either survey but provided lab data.
The CDS SAF dataset consists of:

- CDS Patient File. Contains 1 record for each of the 1,678 patients. A patient record includes a unique identifier USRDS_ID (unique identifier used to cross reference to other USRDS SAF files), demographic data, and a patient category indicator (PAT_CAT_BL), which indicates baseline survey and lab participation status (QOL-only, QOL w/lab data, QOL and nutrition w/o lab data, Lab data w/o survey).
- CDS QOL Baseline File. This file contains the Baseline QOL survey answer data and some derivative score data from QOL only and QOL/ Nutrition participants.
- CDS Food Baseline File. This file contains the Baseline Nutrition survey answer data and data generated by “Block Dietary Data System” on QOL/ Nutrition participants.
- CDS Lab File. This file contains up to five sets of lab data from a subset of QOL/Nutrition participants.
- CDS Dictionary. This file contains each CDS SAF file contents and variable formats.

**Section 12: Medicare Prescription Drug**

Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 amended Title XVIII of the Social Security Act by establishing the Voluntary Prescription Drug Benefit Program (Part D). Effective January 1, 2006, Part D is an optional prescription drug benefit for individuals who are entitled to Medicare benefits under Part A or enrolled in Medicare benefits under Part B. The data from the first few months of 2006, while the benefit was very new, may not be complete, and should be interpreted with caution.

**Data Sources**

The ESRD and pre-ESRD Part D data are obtained from ESRD and pre-ESRD CMS annually with USRDS provided Finder Files. The Part D data are divided into two separate files: an annual enrollment file containing monthly indicators of enrollment in Part D, and a prescription drug event file (PDE) containing details of prescriptions filled by Part D beneficiaries.

**Part D Enrollment SAF**

Since the Part D benefit is voluntary, not all Medicare beneficiaries are enrolled in Part D. The annual enrollment file contains 12 monthly indicators that detail whether the beneficiary is enrolled in Part D, and if so, what type of plan the beneficiary is enrolled in. There are also monthly indicators for dual eligibility (Medicare and Medicaid), monthly indicators for Retiree Drug Subsidy, and low income
subsidy (LIS). A complete listing of the variables included in the annual enrollment file is available in Appendix B: Data File Descriptions.

The variables PTD_CNTRCTID_01-PTD_CNTRCTID_12 indicate Part D enrollment as follows:

- H = Managed care organizations other than Regional Preferred Provider Organization
- R = Regional Preferred Provider Organization
- S = Stand-alone Prescription Drug Plan (PDP)
- E = Employer sponsored
- O = Not Medicare enrolled
- X = Medicare enrolled, but no Part D enrollment record
- N = Not Part D enrolled

Values of H, R, S, and E for these variables are generally considered to indicate Part D enrollment.

Low income subsidy status can be determined from the variables CST_SHR_GRP_CD_01-CST_SHR_GRP_CD_12. If beneficiary is Medicare enrolled and Part D enrolled:

- 01 = 100% premium subsidy and no copayment
- 02 = 100% premium subsidy and low copayment
- 03 = 100% premium subsidy and high copayment
- 04 = LIS, 100% premium-subsidy and high copayment
- 05 = LIS, 100% premium-subsidy and 15% copayment
- 06 = LIS, 75% premium-subsidy and 15% copayment
- 07 = LIS, 50% premium-subsidy and 15% copayment
- 08 = LIS, 25% premium-subsidy and 15% copayment
- 09 = No premium subsidy or cost sharing

If beneficiary is Medicare enrolled and not Part D enrolled:

- 10 = Not enrolled in Part D, but employer is entitled for RDS subsidy
- 11 = Creditable coverage but no RDS
- 12 = Not Part D enrolled, no creditable coverage, no RDS
- 13 = None of the above conditions have been met

**Prescription Drug Event SAF**

This SAF contains details on prescription drug utilization, including brand name, generic name, dosage form, drug strength, quantity dispensed, date of service, and total prescription cost. The
variables in this SAF are listed in Appendix B: Data File Descriptions. More detailed information on the Part D benefit can be found at: http://www.cms.gov/PrescriptionDrugCovGenIn/.