NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Home Health Agency (HHA) Fee-For-Service Value Codes
Date Created: 29JAN2021
Number of Variables: 11

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
PATIENT_ID	NHCS Patient ID	Char	ID	Patient Identifier assigned by NCHS. Researchers requesting linked NHCS-CMS data should use PATIENT_ID.
PUBLICID	NHIS Public Use ID	Char	ID	Public-use survey participant identifier assigned by NCHS. Researchers requesting linked NHIS/LSOA II-Medicare data should use PUBLICID.
SEQN	NHANES Respondent Sequence Number	Num	ID	Public-use survey participant identifier assigned by NCHS. Researchers requesting linked NHEFS/NHANES III/NHANES-Medicare data should use SEQN.
RESNUM	NNHS Resident Record (Case) Number	Num	ID	Public-use survey participant identifier assigned by NCHS. Researchers requesting linked 2004 NNHS-Medicare data should use RESNUM.
SURVEY	Survey Name and survey year/cycle	Char		
FILE_YEAR4	Year of Medicare Fee-for-Service Claim (YYYY)	Num	2016-2018	2016 NHCS has been linked to only 2016-2017 Medicare Data.
NCHS_CLM_ID	NCHS CLAIM ID	Num		
NCH_CLM_TYPE_CD	NCH Claim Type Code	Char	10	HHA claim
RLT_VAL_CD_SEQ	Claim Related Value Code Sequence	Char		
CLM_VAL_CD	Claim Value Code	Char	**OTHER**	Miscoded
			12	Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
			13	Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			14	That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
			15	That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
			17	Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry).
			21	Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
			22	Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
			24	Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
			41	Amount is that portion of a payment from higher priority BL program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
			43	Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.
			44	Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due.
			47	Any liability insurance - Amount is that portion from a higher priority liability insurance made on behalf of Medicare bene the provider is applying to Medicare covered services on this bill. (Eff 9/93)
			50	Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.

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			51	Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
			52	Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.
			56	Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
			61	Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.
			62	Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
			63	Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
			64	Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
			65	Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
			70	Interest amount - (Providers do not report this.) Report the amount applied to this bill.
			73	Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.
			76	Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)
			80	Covered Days
			81	Non-Covered Days

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			83	Lifetime Reserve Days
			A2	Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
			A3	Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.
			A6	Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.
			Q0	ACO Payment Adjustment Amount (Pioneer Reduction) - the amount that would have been paid if not for the Pioneer reduction. (eff. 1/2014)
			Q1	ACO Payment Reduction Amount (Pioneer Reduction) - the actual amount of the Pioneer reduction. (eff. 1/2014)
			QN	First APC device offset
			QO	Second APC device offset
			QP	Reserved for future use
			QQ	Terminated procedure with pass-through device OR condition for device credit present
			QR	First APC pass-through drug or biological offset
			QS	Second APC pass-through drug or biological offset
			QT	Third APC pass-through drug or biological offset
			QU	Reserved for future use
			QV	Home Health Value Based Purchasing (HHVBP) adjustment amount (negative or positive; eff 4/2018)
			QW	Reserved for future use

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Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			XX	Total Charge Amount for all Part A visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part A visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
			XY	Total Charge Amount for all Part B visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part B visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
			XZ	Total Charge Amount for all Part B nonvisit charges on the RIC 'U' claims - for Home Health claims containing both Part A & Part B services, this code identifies the total charge amount for the Part B non-visit charges. Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
CLM_VAL_AMT	Claim Value Amount	Num	0-7,260,000	Payment/Chagred Amount, in dollars.

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