**NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data**
**Hospice 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 | 50 | Hospice claim |
| | | | | |
| RLT_VAL_CD_SEQ | Claim Related Value Code Sequence | Char | | |
| | | | | |
| CLM_VAL_CD | Claim Value Code | Char | **OTHER** | Miscoded |
| | | | 02 | Hospital Has No Semi-Private Rooms - Entering this code requires $0.00 amount. |
| | | | 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. |

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

| Variable Name | Variable (VAR) Label | VAR Type | Range of Values[1] | Value Description |
|---|---|---|---|---|
| | | | 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. |
| | | | 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. |
| | | | 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) |
| | | | 48 | Hemoglobin reading - The patient's most recent hemoglobin reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during the billing cycle. |
| | | | 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. |
| | | | 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. |

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

| Variable Name | Variable (VAR) Label | VAR Type | Range of Values[1] | Value Description |
|---|---|---|---|---|
| | | | 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 |
| | | | 82 | Coinsurance Days |
| | | | 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. |
| | | | G8 | Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08) |
| | | | 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 |

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

**NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data**
**Hospice 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 |
|---|---|---|---|---|
| | | | 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 |
| | | | | |
| CLM_VAL_AMT | Claim Value Amount | Num | 0-178,600 | Payment/Chagred Amount, in dollars. |
| | | | | |

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