NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Inpatient 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	60	Inpatient claim
RLT_VAL_CD_SEQ	Claim Related Value Code Sequence	Char		
CLM_VAL_CD	Claim Value Code	Char	**OTHER**	Miscoded
			01	Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
			02	Hospital Has No Semi-Private Rooms - Entering this code requires $0.00 amount.
			03	Reserved for national assignment.

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

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

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			04	Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
			05	Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
			06	Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
			08	Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)
			09	Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission. (not stored in NCH until 2/93)
			10	Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years. (in NCH until 2/93)
			11	Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years (not stored in NCH until 2/93)
			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.
			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.

[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
			16	That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate 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).
			18	Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry).
			19	Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment 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)
			23	Recurring monthly income - 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)
			29	Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropratic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
			31	Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.
			37	Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient. (eff 10/93)

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

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

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			38	Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)
			39	Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)
			40	New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
			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.
			42	Amount is that portion of a payment from higher priority VA 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.
			45	Accident Hour - The hour the accident occurred that necessitated medical treatment.
			46	Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care. (eff 10/93)
			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)

[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
			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.
			49	Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing cycle.
			50	Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.
			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.
			53	Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.
			54	New birth weight in grams - Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of '4' and on other claims as required by law.
			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.
			66	Medicare Spend-down Amount -- The dollar amount that was used to meet the recipient's spend-down liability for this claim.
			68	EPO drug - Number of units of EPO administered relating to the billing period.
			69	Reserved for national assignment
			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
			74	Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.
			75	Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.
			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)
			77	New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary. (eff. 4/1/03, under Inpatient PPS)
			80	Covered Days
			81	Non-Covered Days
			82	Coinsurance Days
			83	Lifetime Reserve Days
			85	Medicare Coinsurance Amount in the third or greater calendar years'. (eff. 1/7/2013)
			90	Cell Therapy Invoice Cost (eff. 4/2020)
			91-99	Reserved for national assignment.
			A0	Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)
			A1	Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the invovling the indicated payer. (eff. 10/93) - Prior value 07
			A3	Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.

[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
			A4	Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma. (eff 7/97)
			A5	Covered self-administered drugs -- The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to the patient.
			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.
			A8	Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.
			A9	Patient Height - Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
			AB	Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer (eff. 10/2003).
			B1	Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
			B3	Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
			C1	Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
			D3	Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.
			D4	Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 10/1/07)

[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
			D5	Result of last Kt/V. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service. (eff. 7/1/10)
			FC	Patient Paid Amount. The amount the provider has received from the patient toward payment of this bill (7/1/08).
			FD	Credit Received from the Manufacturer for a Replaced Medical Device - the amount the provider has received from a medical device manufacturer as credit for a replaced device. (eff. 7/1/08)
			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)
			Q5	Electronic health record (EHR)-Reduction
			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

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

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

Variable Name	Variable (VAR) Label	VAR Type	Range of Values[1]	Value Description
			Y1	Part A demo payment - Portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
			Y2	Part B demo payment - Portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.
			Y3	Part B coinsurance - Amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
			Y4	Conventional Provider Payment Amount for Non-Demonstration Claims - This the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
			Y5	Part B deductible, applicable for a Model 4 demonstration 64 claims
CLM_VAL_AMT	Claim Value Amount	Num	0-10,000,000	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.