

## Skilled Nursing Facility (SNF) Encounter Value Codes

Date Created: 29JAN2021

Number of Variables: 10

Variable Name	Variable (VAR) Label	VAR Type	Range of Values	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 Advantage (MA) Encounter (YYYY)	Num	2016	2016 NHCS has been linked to only 2016-2017 Medicare Data.
NCHS_ENC_JOIN_KEY	NCHS ENCOUNTER JOIN KEY	Num		
CLM_TYPE_CD	Claim Type Code	Char	4018	Hospital Swing Beds
			4021	SNF Skilled Nursing Inpatient
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.
			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)

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			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)
			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.
			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.
			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.
			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)
			25	Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).
			29	Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropractic 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.

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			32	Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination. (eff. 4/1/2003)
			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)
			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.
			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.
			60	HHA branch MSA - MSA in which HHA branch is located.
			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.
			68	EPO drug - Number of units of EPO administered relating to the billing period.
			80	Covered Days
			81	Non-Covered Days
			82	Coinsurance Days
			83	Lifetime Reserve Days
			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)
			A3	Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.

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			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.
			B3	Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
			D3	Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.
			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).