Restricted-use Linked NCHS-CMS Medicare Data
Home Health Agency (HHA) Value Codes
DATE CREATED: 02FEB2017
Number of Variables: 11

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
SURVEY	NCHS SURVEY NAME	Char	20	-	
PUBLICID	NHIS PUBLIC USE ID	Char	14	ID	
SEQN	NHANES SAMPLE SEQUENCE NUMBER (PUBLIC ID)	Num	8	ID	
RESNUM	NNHS RESIDENT ID NUMBER (PUBLIC)	Num	8	ID	
PATNUM	Patient/Discharge Record (Case) Number in public-use file	Num	8	ID	
FILE_YEAR4	Beneficiary Enrollment Reference Year (YYYY)	Num	4	1999-2013	
NCHS_CLM_ID	NCHS CLAIM ID	Num	8		
NCH_CLM_TYPE_CD	NCH Claim Type Code	Char	2	10	HHA claim
RLT_VAL_CD_SEQ	Claim Related Value Code Sequence	Char	2	-	
CLM_VAL_CD	Claim Value Code	Char	2	**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.
				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 condition
				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 condit
				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 cla

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
				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 conditio
				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
				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)
				26	Prescription Drugs Offset to Patient (Payment Amount - Hearing and Ear Services) Hearing and ear services paid for out of a long term care facility resident/patient's funds in the billing period submi
				27	Offset to the Patient (Payment Amount - Vision and Eye Services) - Vision and eye services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement
				34	Offset to the Patient Payment Amount (Medical Services) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
				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)
				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 con
				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 t
				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 Medi
				45	Accident Hour - The hour the accident occurred that necessitated medical treatment.
				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 9/9
				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.

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Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
				55	Eligibility Threshold for Charity Care - code identifies the corresponding value amount at which a health care facility determines the eligibility threshold of charity care.
				56	Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
				57	Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.
				59	Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth mo
				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 th
				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)
				66	Medicare Spend-down Amount -- The dollar amount that was used to meet th4e recipient's spend-down liability for this claim.
				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.
				74	Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance 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 delimite
				80	Reserved for state assignment.
				81	Reserved for state assignment.

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
				82	Reserved for state assignment.
				83	Reserved for state assignment.
				84	Reserved for state assignment.
				85	Reserved for state assignment.
				86	Reserved for state assignment.
				87	Reserved for state assignment.
				88	Reserved for state assignment.
				89	Reserved for state assignment.
				90	Reserved for state assignment.
				91	Reserved for state assignment.
				92	Reserved for state assignment.
				93	Reserved for state assignment.
				94	Reserved for state assignment.
				95	Reserved for state assignment.
				96	Reserved for state assignment.
				97	Reserved for state assignment.
				98	Reserved for state assignment.
				99	Reserved for state assignment.
				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 diagn
				B2	Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
				D3	Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
				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)
				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 (base
				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 (base
				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
CLM_VAL_AMT	Claim Value Amount	Num	8		