NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Home Health Agency (HHA) 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	4032	Home Health + Inpatient (covered by Medicare Part B – not Part A)
RLT_VAL_CD_SEQ	Claim Related Value Code Sequence	Char		
CLM_VAL_CD	Claim Value Code	Char	01	Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
			04	Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
			06	Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
			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.

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			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
			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)
			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.
			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)
			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.
			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.

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			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.
			80	Covered Days
			81	Non-Covered Days
			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.
			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.
			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).