NCHS Survey Data Linked to CMS MBSF, Claims/Encounters, and Assessment Data
Inpatient 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	4011	Hospital 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.
			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.

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			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)
			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.
			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).
			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)

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			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)
			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.
			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)
			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.)
			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.

Variable Name	Variable (VAR) Label	VAR Type	Range of Values	Value Description
			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)
			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.
			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.
			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

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			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.
			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.
			AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
			AB	Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer (eff. 10/2003).
			B3	Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
			C3	Estimated Responsibility Payer C - The stop
			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)

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			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)