Summary Medicare Enrollment and Claims Files (SMEC)
1991-2007

SURVEY NCHS Survey linked to CMS Medicare administrative records

NCHS survey linked to CMS Medicare enrollment and claims data.

Type: Character **Width:** 16

Usage Notes:

There is a separate data file for each year of Medicare coverage (1991-2007).

A SMEC file is available for each year (1999-2007) of available linked Medicare data for the following NCHS surveys:

1999-2005 National Health Interview Survey (NHIS)
1999-2004 National Health and Nutrition Examination Survey (NHANES)
2004 National Nursing Home Survey (NNHS)

A SMEC file is available for each year (1991-2007) of available linked Medicare data for the following NCHS surveys:

1994-1998 National Health Interview Survey (NHIS)
NHANES I Epidemiologic Follow-up Study (NHEFS)
Third National Health and Nutrition Examination Survey (NHANES III)
The Second Longitudinal Study of Aging (LSOA II)

PUBLICID* NCHS Survey Identifier – Participant Identification Number*

Public use identifier assigned by NCHS used to link NCHS survey data and administrative records.

Type: Character **Width:** 14

Usage Notes:

See Appendix A for NCHS survey specific descriptions.

***Researchers linking to the following surveys should use PUBLICID:**
1994-2005 NHIS and LSOA II
Researchers linking to the following surveys should use SEQN:
NHEFS, NHANES III and 1999-2004 NHANES
Researchers linking to the following survey should use RESNUM:
2004 NNHS

SEQN* NCHS Survey Identifier - Sample Sequence Number *

Public use identifier assigned by NCHS used to link NCHS survey data and administrative records.

Type: Numeric **Width:** 5

Usage Notes:

See Appendix A for NCHS survey specific descriptions.

***Researchers linking to the following surveys should use PUBLICID:**
1994-2005 NHIS and LSOA II
Researchers linking to the following surveys should use SEQN:
NHEFS, NHANES III and 1999-2004 NHANES
Researchers linking to the following survey should use RESNUM:
2004 NNHS

RESNUM* NCHS Survey Identifier - Resident Record (Case) Number *

Public use identifier assigned by NCHS used to link NCHS survey data and administrative records.

Type: Numeric **Width:** 6

Usage Notes:

See Appendix A for NCHS survey specific descriptions.

***Researchers linking to the following surveys should use PUBLICID:**
1994-2005 NHIS and LSOA II
Researchers linking to the following surveys should use SEQN:
NHEFS, NHANES III and 1999-2004 NHANES
Researchers linking to the following survey should use RESNUM:
2004 NNHS

FILE_YEAR4 Medicare Claim Year

Year Medicare claims were filed.

Type: Numeric **Width:** 4 **Format:** CCYY

Possible Values: 1991 – 2007

Usage Notes:

There is a separate data file for each year of Medicare coverage (1991-2007).

A SMEC file is available for each year (1999-2007) of available linked Medicare data for the following NCHS surveys:

1999-2005 National Health Interview Survey (NHIS)
1999-2004 National Health and Nutrition Examination Survey (NHANES)
2004 National Nursing Home Survey (NNHS)

A SMEC file is available for each year (1991-2007) of available linked Medicare data for the following NCHS surveys:

1994-1998 National Health Interview Survey (NHIS)
NHANES I Epidemiologic Follow-up Study (NHEFS)
Third National Health and Nutrition Examination Survey (NHANES III)
The Second Longitudinal Study of Aging (LSOA II)

H_RACE Race

Race of the Medicare beneficiary.

Type: Character **Width:** 1

Possible Values:

0 = Unknown
1 = White
2 = Black
3 = Other
4 = Asian
5 = Hispanic
6 = North American Native

Source: Denominator File - RACE_CODE (Beneficiary Race Code)

Usage Notes:

H_RACE equals RACE_CODE (Beneficiary Race Code).

The values reported for race may be different for each Medicare year and may differ from the values in the survey.

H_DOD Date of Death

Date of death of the Medicare beneficiary.

Type: Numeric **Width:** 8 **Format:** YYYYMMDD

Possible Values:

19910101-20080331
00000000 = Not dead

Source: Denominator File - DATE_OF_DEATH (Beneficiary Date of Death Code)

Usage Notes:

H_DOD equals DATE_OF_DEATH (Beneficiary Date of Death Code).

If day of death is unknown, the day is coded as the last day of the month.

H_MEDSTAT Medicare Status Code

This field specifies the reason for the beneficiary's Medicare entitlement

Type: Character **Width:** 2

Possible Values:

10 = Aged Without End Stage Renal Disease (ESRD)
11 = Aged With ESRD
20 = Disabled Without ESRD
21 = Disabled With ESRD
31 = ESRD Only

Source:

Denominator File - MEDICARE_STATUS_CODE (Medicare Status Code)

Usage Notes:

ESRD - End Stage Renal Disease

H_MEDSTAT equals MEDICARE_STATUS_CODE (Medicare Status Code).

This field is coded by CMS using Age, Original Reason for Entitlement, Current Reason for Entitlement and ESRD indicator from the CMS Enrollment Data Base (EDB).

This field contains the most recent values as of March of the year following the claim year identified in FILE_YEAR4.

Analysts should be aware that disagreement between the Current Reason for Entitlement (H_CREC) and Medicare Status code is possible if variables are updated at different times on the EDB or if one variable is not populated for any reason. If variables are not populated on the EDB, then CMS imputes these values using Age and ESRD variables from the denominator file.

H_TERMPTA Part A Termination Code

This code specifies the reason Medicare Part A entitlement was terminated.

Type: Character **Width:** 1

Possible Values:

Codes effective 1992
- 0 = Not terminated
- 1 = Dead
- 2 = Non-payment of premium
- 3 = Voluntary withdrawal
- 4 = Entitlement under another claim number (*only on 1991 files*)
- 6 = Unknown value (*only on 1991 files*)
- 9 = Other termination

Source:

Denominator File - PART_A_TERMINATION_CODE (Beneficiary Part A Termination Code)

Usage Notes:

H_TERMPTA equals PART_A_TERMINATION_CODE (Beneficiary Part A Termination Code).

The 1991 Denominator file contains some values of '6' for this variable. There is no definition available for a value of '6'. Researchers using the 1991 data files should use this variable with caution.

H_TERMPTB Part B Termination Code

This code specifies the reason Medicare Part B entitlement was terminated.

Type: Character **Width:** 1

Possible Values:

Codes effective 1992
- 0 = Not terminated
- 1 = Dead
- 2 = Non-payment of premium
- 3 = Voluntary withdrawal
- 4 = Entitlement under another claim number (*only on 1991 files*)
- 6 = Unknown value (*only on 1991 files*)
- 9 = Other termination

Source:

Denominator File - PART_B_TERMINATION_CODE (Beneficiary Part B Termination Code)

Usage Notes:

H_TERMPTB equals PART_B_TERMINATION_CODE (Beneficiary Part B Termination Code).

The 1991 Denominator file contains some values of '6' for this variable. There is no definition available for a value of '6'. Researchers using the 1991 data files should use this variable with caution.

H_CREC Current Reason for Medicare Entitlement

This field indicates the reason for the beneficiary's current entitlement to Medicare benefits.

Type: Character **Width:** 1

Possible Values:

0 = Old Age and Survivors Insurance (OASI)
1 = Disability Insurance Benefits (DIB)
2 = End Stage Renal Disease (ESRD)
3 = DIB and ESRD

Source:

Denominator File – CURR_REASON_FOR_ENTITLEMENT (Current Reason for Entitlement)

Usage Notes:

H_CREC equals CURR_REASON_FOR_ENTITLEMENT (Current Reason for Entitlement)

Current reason for Medicare Entitlement comes from the Denominator file and is coded by CMS using data from the Enrollment Data Base (EDB).

This field contains the most recent values as of March of the year following the claim year identified in FILE_YEAR4.

H_OREC Original Reason for Medicare Entitlement

This field indicates the reason for the beneficiary's original entitlement to Medicare benefits.

Type: Character **Width:** 1

Possible Values:

0 = Old Age and Survivors Insurance (OASI)
1 = Disability Insurance Benefits (DIB)
2 = End Stage Renal Disease (ESRD)
3 = Both DIB and ESRD

Source:

Denominator File – ORIG_REASON_FOR_ENTITLEMENT (Original Reason for Entitlement)

Usage Notes:

H_OREC equals ORIG_REASON_FOR_ENTITLEMENT (Original Reason for Entitlement)

Original reason for Medicare Entitlement comes from the Denominator file and is coded by CMS using data from the Social Security Administration and/or Railroad Retirement Board Beneficiary Record Systems.

H_MDCOVRG Total Months of Medicare Entitlement

Total months of Medicare entitlement for the year.

Type: Numeric **Width:** 2

Possible Values:

1 – 12 months

Source:

Denominator File - ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) for each year.

H_MDCOVRG adds 1 for each of the Medicare monthly entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) **NOT** equal to '0'.

H_MEDEPTA Total Months of Medicare Entitlement – Part A Only

Total months of Medicare Part A entitlement.

Type: Numeric **Width:** 2

Possible Values:

0 – 12 months

Source:

Denominator File - ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) for each year.

H_MEDEPTA adds 1 for each of the Medicare monthly entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) equal to '1'.

H_MEDEPTB Total Months of Medicare Entitlement – Part B Only

Total months of Medicare Part B entitlement.

Type: Numeric **Width:** 2

Possible Values:

0 – 12 months

Source:

Denominator File - ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) for each year.

H_MEDEPTB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) equal to '2'.

H_MDEPTAB Total Months of Medicare Entitlement – Parts A and B

Total months of Medicare Part A and B entitlement.

Type: Numeric **Width:** 2

Possible Values:

0 – 12 months

Source:

Denominator File - ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) for each year.

H_MDEPTAB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) equal to '3'.

H_MEDSPTA Total Months of Medicare State Buy-In – Part A Only

Total months of Medicare Part A state buy-in.

Type: Numeric **Width:** 2

Possible Values:

0 – 12 months

Source:

Denominator File - ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) for each year.

H_MEDSPTA adds 1 for each of the Medicare monthly entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) equal to ‘A’.

H_MEDSPTB Total Months of Medicare State Buy-In – Part B Only

Total months of Medicare Part B state buy-in.

Type: Numeric **Width:** 2

Possible Values:

0 – 12 months

Source:

Denominator File - ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) for each year.

H_MEDSPTB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) equal to ‘B’.

H_MDSPTAB Total Months of Medicare State Buy-In – Parts A and B

Total months of Medicare Part A and B state buy-in.

Type: Numeric **Width:** 2

Possible Values:

0 – 12 months

Source:

Denominator File - ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) for each year.

H_MDSPTAB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (ENTITLEMENT_BUY_IN_IND1 – ENTITLEMENT_BUY_IN_IND12) equal to ‘C’.

H_HMOENRL Total Months of HMO Enrollment

Total months of HMO enrollment for the year.

Type: Numeric **Width:** 2

Possible Values:

0 – 12 months

Source:

Denominator File - HMO_INDICATOR1 – HMO_INDICATOR12 (HMO monthly enrollment indicators)

Usage Notes:

There are 12 monthly occurrences of HMO enrollment indicators (HMO_INDICATOR1 – HMO_INDICATOR12) for each year.

H_HMOENRL adds 1 for each of the HMO monthly enrollment indicators (HMO_INDICATOR1 – HMO_INDICATOR12) **NOT** equal to '0', '4' or '9' when FILE_YEAR4 (Medicare Claim Year) equals '1991'.

H_HMOENRL adds 1 for each of the HMO monthly enrollment indicators (HMO_INDICATOR1 – HMO_INDICATOR12) **NOT** equal to '0' or '4' when FILE_YEAR4 (Medicare Claim Year) equals '1992' through '2007'.

There may be slight differences between the values of H_HMOENRL and HMO_COVERAGE on the Medicare Denominator File. The calculation of HMO_COVERAGE includes values of '4' and '9' for the HMO monthly enrollment indicators (HMO_INDICATOR1 – HMO_INDICATOR12).

This variable provides information on whether a Medicare beneficiary received Medicare services as an enrollee in a group health maintenance organization, or Medicare Part C plan. Information on health care services utilization will not be available for most Medicare beneficiaries who participate in Medicare Part C plans because CMS generally does not receive claims data for Medicare beneficiaries who enroll in these plans (including private fee-for-service plans paid on a capitation basis). Medicare Part C plans are also referred to as Medicare Advantage (MA) and include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Researchers should consider the implications of including Medicare Part C enrollees in the samples for analysis.

During the time covered by the linked database, enrollment in Medicare Part C increased from approximately 6% of beneficiaries in 1991 to 20% in 2007. In general, studies based on analysis of claims data should exclude Medicare Part C enrollees from their beneficiary samples. Additional information regarding analytic issues with the NCHS-CMS Medicare linked data files can be found in Medicare Enrollment and Claims Data Analytic Issues.

H_HMOMNTH First Month of HMO Enrollment

First month of HMO enrollment for the year.

Type: Numeric **Width:** 2

Possible Values:

1 = January
2 = February
3 = March
4 = April
5 = May
6 = June
7 = July
8 = August
9 = September
10 = October
11 = November
12 = December
Blank = Not enrolled in HMO during the claim year

Source:

Denominator File - HMO_INDICATOR1 – HMO_INDICATOR12 (HMO monthly enrollment indicators)

Usage Notes:

There are 12 monthly occurrences of HMO enrollment indicators (HMO_INDICATOR1 – HMO_INDICATOR12) for each year.

H_HMOMNTH indicates the first month a value **NOT** equal to '0', '4' or '9' appears in the HMO monthly enrollment indicators (HMO_INDICATOR1 – HMO_INDICATOR12) when FILE_YEAR4 (Medicare Claim Year) equals '1991'.

H_HMOMNTH indicates the first month a value **NOT** equal to '0' or '4' appears in the HMO monthly enrollment indicators (HMO_INDICATOR1 – HMO_INDICATOR12) when FILE_YEAR4 (Medicare Claim Year) equals '1992' through '2007'.

This variable provides information on whether a Medicare beneficiary received Medicare services as an enrollee in a group health maintenance organization, or Medicare Part C plan. Information on health care services utilization will not be available for most Medicare beneficiaries who participate in Medicare Part C plans because CMS generally does not receive claims data for Medicare beneficiaries who enroll in these plans (including private fee-for-service plans paid on a capitation basis). Medicare Part C plans are also referred to as Medicare Advantage (MA) and include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Researchers should consider the implications of including Medicare Part C enrollees in the samples for analysis.

During the time covered by the linked database, enrollment in Medicare Part C increased from approximately 6% of beneficiaries in 1991 to 20% in 2007. In general, studies based on analysis of claims data should exclude Medicare Part C enrollees from their beneficiary samples. Additional information regarding analytic issues with the NCHS-CMS Medicare linked data files can be found in Medicare Enrollment and Claims Data Analytic Issues.

H_TOTRMB Total Medicare Reimbursement

A summation (rounded to whole dollars) for the year of the total amount of payment made from the Medicare trust fund for services or procedures covered by all Medicare claims. Includes reimbursement amounts from inpatient, skilled nursing facility (SNF), home health agency (HHA), hospice, outpatient, physician and durable medical equipment (DME) claims.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Medicare claims data),
-999999 – 9999999

Usage Notes:

H_TOTRMB equals H_INPRMB (Inpatient Reimbursement) + H_SNFRMB (SNF Reimbursement) + H_HHRMBA (HHA Reimbursement Part A) + H_HHRMBB (HHA Reimbursement Part B) + H_HSREIM (Hospice Reimbursement) + H_OUTRMB (Outpatient Reimbursement) + H_PHYRMB (Physician Reimbursement) + H_DMERMB (DME Reimbursement).

H_TOTEXP Total Medicare Expenditures

A summation (rounded to whole dollars) for the year of the total amount of payment made from the Medicare trust fund and by the beneficiary for services or procedures covered by all Medicare claims. Includes total payment amounts from inpatient, skilled nursing facility (SNF), home health agency (HHA), hospice, outpatient, physician and durable medical equipment (DME) claims.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Medicare claims data),
-999999 – 9999999

Usage Notes:

H_TOTEXP equals H_INPEXP (Inpatient Total Expenditures) + H_SNFEXP (SNF Total Expenditures) + H_HHAEXP (HHA Total Expenditures) + H_HSEXP (Hospice Total Expenditures) + H_OUTEXP (Outpatient Total Expenditures) + H_PHYEXP (Physician Total Expenditures) + H_DMEEXP (DME Total Expenditures).

Payments for prescriptions drugs covered by Medicare Part D are not included in the calculation of H_TOTEXP.

Researchers using 2006-2007 SMEC files who wish include prescription drug payments in the calculation of total Medicare expenditures should add H_TOTEXP + H_PDEGDC (Gross Prescription Drug Cost).

H_LATDCH Discharge Date of Latest Inpatient Stay

The discharge date associated with the last inpatient stay for the year.

Type: Character **Width:** 8 **Format:** CCYYMMDD

Possible Values:

Blank (No Inpatient Stay claims data),
19910101 – 20071231

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_DSCHRG_DT (MedPAR Discharge Date)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_LATDCH equals MEDPAR_DSCHRG_DT (MedPAR Discharge Date) located on the last inpatient stay record for the year.

H_LATDRG Diagnosis Related Group (DRG) Code for Latest Inpatient Stay

The DRG code associated with the last inpatient stay for the year.

Type: Character **Width:** 3

Possible Values:

Blank (No Inpatient Stay claims data),
1 – 999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_DRG_CD (MedPAR DRG Code)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_LATDRG equals MEDPAR_DRG_CD (MedPAR DRG Code) located on the last inpatient stay record for the year.

H_DISDES Discharge Status for Latest Inpatient Stay

The discharge status associated with the last inpatient stay for the year.

Type: Character **Width:** 1

Possible Values:

A = Discharged Alive
B = Discharged Dead
Blank = No Inpatient Stay claims data

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_BENE_DSCHRG_STUS_CD (MedPAR Beneficiary Discharge Status Code)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_DISDES equals MEDPAR_BENE_DSCHRG_STUS_CD (MedPAR Beneficiary Discharge Status Code) located on the last inpatient stay record for the year.

H_INPSTY Number of Inpatient Stays

Total number of inpatient stays for the year.

Type: Numeric **Width:** 2

Possible Values:

Blank (No Inpatient Stay claims data),
1 – 99 stays

Source:

MedPAR File

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_INPSTY adds 1 for each inpatient stay until all inpatient stays for an individual have been totaled for the year.

H_INPDAY Number of Inpatient Covered Days

Total count of all inpatient covered days of care for the year.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Inpatient Stay claims data),
0 – 999 days

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_UTLZTN_DAY_CNT (MedPAR Utilization Day Count)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_INPDAY adds MEDPAR_UTLZTN_DAY_CNT (MedPAR Utilization Day Count) until all inpatient covered days for an individual have been totaled for the year.

H_INPCHG Inpatient Charges

The total amount of all inpatient covered and non-covered charges (rounded to whole dollars) for the year.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Inpatient Stay claims data),
0 – 9999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_TOT_CHRG_AMT (MedPAR Total Charge Amount)

Usage Notes:

An individual may have one or more inpatient stay records in any given year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_INPCHG adds MEDPAR_TOT_CHRG_AMT (MedPAR Total Charge Amount) until all inpatient charges (covered and non-covered) have been totaled for the year.

H_INPCCH Inpatient Covered Charges

The portion of inpatient total charges covered by Medicare (rounded to whole dollars) for the year.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Inpatient Stay claims data),
0 – 9999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_TOT_CVR_CHRG_AMT (MedPAR Total Covered Charge Amount)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_INPCCH adds MEDPAR_TOT_CVR_CHRG_AMT (MedPAR Total Covered Charge Amount) until all inpatient covered charges for an individual have been totaled for the year.

H_INPRMB Inpatient Reimbursement

A summation (rounded to whole dollars) for the year of: (1) the amount of payment made from the Medicare trust fund for inpatient services covered by the claim; and (2) the total of all inpatient claim pass through amounts.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Inpatient Stay claims data),
-99999 – 9999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount)

MedPAR File - MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_INPRMB equals MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount) + MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount).

H_INPRMB adds (MEDPAR_MDCR_PMT_AMT + MEDPAR_PASS_THRU_AMT) until all inpatient reimbursements for an individual have been totaled for the year.

H_INPCDY Inpatient Coinsurance Days Used

The total count of inpatient coinsurance days for the year.

Type: Numeric **Width:** 2

Possible Values:

Blank (No Inpatient Stay claims data),
0 – 99 days

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_TOT_COINSRNC_DAY_CNT (MEDPAR Beneficiary Total Coinsurance Day Count)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_INPCDY adds MEDPAR_TOT_COINSRNC_DAY_CNT (MEDPAR Beneficiary Total Coinsurance Day Count) until all inpatient coinsurance days for an individual have been totaled for the year.

H_INPCAM Inpatient Coinsurance Amount

Amount of money (rounded to whole dollars) for the year identified as the beneficiary's liability for Part A coinsurance for all inpatient stays.

Type: Numeric **Width:** 5 **Format:** $$$$$

Possible Values:

Blank (No Inpatient Stay claims data),
0 – 99999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals "L" or "S".

H_INPCAM adds MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount) until all inpatient coinsurance amounts for an individual have been totaled for the year.

H_INPEXP Inpatient Total Expenditures

A summation (rounded to whole dollars) for the year of: (1) the amount of payment made from the Medicare trust fund for inpatient services covered by the claim; (2) the total of all inpatient claim pass through amounts; (3) the of all inpatient payments made by the beneficiary; and (4) the total of all inpatient payments made by the primary payer.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Inpatient Stay claims data),
-99999 – 9999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount)

MedPAR File - MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount)

MedPAR File - MEDPAR_BENE_IP_DDCTBL_AMT (MedPAR Beneficiary Inpatient Deductible Liability Amount)

MedPAR File - MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount)

MedPAR File - MEDPAR_BENE_BLOOD_DDCTBL_AMT (MedPAR Beneficiary Blood Deductible Liability Amount)

MedPAR File - MEDPAR_BENE_PRMRY_PYR_AMT (MedPAR Beneficiary Primary Payer Amount)

Usage Notes:

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_INPEXP equals MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount) + MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount) + MEDPAR_BENE_IP_DDCTBL_AMT (MedPAR Beneficiary Inpatient Deductible Liability Amount) + MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount) + MEDPAR_BENE_BLOOD_DDCTBL_AMT (MedPAR Beneficiary Blood Deductible Liability Amount) + MEDPAR_BENE_PRMRY_PYR_AMT (MedPAR Beneficiary Primary Payer Amount).

H_INPEXP adds (MEDPAR_MDCR_PMT_AMT + MEDPAR_PASS_THRU_AMT + MEDPAR_BENE_IP_DDCTBL_AMT + MEDPAR_BENE_PTA_COINSRNC_AMT + MEDPAR_BENE_BLOOD_DDCTBL_AMT + MEDPAR_BENE_PRMRY_PYR_AMT) until all inpatient expenditures for an individual have been totaled for the year.

H_SNFSTY Number of Skilled Nursing Facility (SNF) Stays

Total number of SNF stays for the year.

Type: Numeric **Width:** 2

Possible Values:

Blank (No Skilled Nursing Facility claims data),
1 – 99 stays

Source:

MedPAR File

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “N”.

H_SNFSTY adds 1 for each SNF stay until all SNF stays for an individual have been totaled for the year.

H_SNFDAY Number of SNF Covered Days

Total count of all SNF covered days of care for the year.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Skilled Nursing Facility claims data),
0 – 999 days

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File – MEDPAR_UTLZTN_DAY_CNT (MedPAR Utilization Day Count)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “N”.

H_SNFDAY adds MEDPAR_UTLZTN_DAY_CNT (MedPAR Utilization Day Count) until all SNF covered days for an individual have been totaled for the year.

H_SNFCHG SNF Charges

The total amount of all SNF covered and non-covered charges (rounded to whole dollars) for the year.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Skilled Nursing Facility claims data),
0 – 9999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File – MEDPAR_TOT_CHRG_AMT (MedPAR Total Charge Amount)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “N”.

H_SNFCHG adds MEDPAR_TOT_CHRG_AMT (MedPAR Total Charge Amount) until all SNF charges (covered and non-covered) for an individual have been totaled for the year.

H_SNFCCH SNF Covered Charges

The portion of total SNF charges (rounded to whole dollars) for the year covered by Medicare.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Skilled Nursing Facility claims data),
0 – 999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File – MEDPAR_TOT_CVR_CHRG_AMT (MedPAR Total Covered Charge Amount)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “N”.

H_SNFCCH adds MEDPAR_TOT_CVR_CHRG_AMT (MedPAR Total Covered Charge Amount) until all SNF covered charges for an individual have been totaled for the year.

H_SNFRMB SNF Reimbursement

A summation (rounded to whole dollars) for the year of: (1) the amount of payment made from the Medicare trust fund for SNF services covered by the claim; and (2) the total of all SNF claim pass through amounts.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Skilled Nursing Facility claims data),
-99999 – 999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File – MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount)

MedPAR File – MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “N”.

H_SNFRMB equals MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount) + MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount).

H_SNFRMB adds (MEDPAR_MDCR_PMT_AMT + MEDPAR_PASS_THRU_AMT) until all SNF reimbursements for an individual have been totaled for the year.

H_SNFCDY SNF Coinsurance Days Used

The total count of SNF coinsurance days for the year.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Skilled Nursing Facility claims data),
0 – 999 days

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File – MEDPAR_TOT_COINSRNC_DAY_CNT (MedPAR Beneficiary Total Coinsurance Day Count)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “N”.

H_SNFCDY adds MEDPAR_TOT_COINSRNC_DAY_CNT (MedPAR Beneficiary Total Coinsurance Day Count) until all SNF coinsurance days for an individual have been totaled for the year.

H_SNFCAM SNF Coinsurance Amount

Amount of money (rounded to whole dollars) for the year identified as the beneficiary's liability for Part A coinsurance for SNF stays.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Skilled Nursing Facility claims data),
0 – 999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File – MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals "N".

H_SNFCAM adds MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount) until all SNF coinsurance amounts for an individual have been totaled for the year.

H_SNFEXP SNF Total Expenditures

A summation (rounded to whole dollars) for the year of: (1) the amount of payment made from the Medicare trust fund for SNF services covered by the claim; (2) the total of all SNF claim pass through amounts; (3) the of all SNF payments made by the beneficiary; and (4) the total of all SNF payments made by the primary payer.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Inpatient Stay claims data),
-99999 – 999999

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount)

MedPAR File - MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount)

MedPAR File - MEDPAR_BENE_IP_DDCTBL_AMT (MedPAR Beneficiary Inpatient Deductible Liability Amount)

MedPAR File - MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount)

MedPAR File - MEDPAR_BENE_BLOOD_DDCTBL_AMT (MedPAR Beneficiary Blood Deductible Liability Amount)

MedPAR File - MEDPAR_BENE_PRMRY_PYR_AMT (MedPAR Beneficiary Primary Payer Amount)

Usage Notes:

An individual may have one or more SNF stay records for the year.

A MedPAR claims record is considered a SNF stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “N”.

H_SNFEXP equals MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount) + MEDPAR_PASS_THRU_AMT (MedPAR Total Pass Through Amount) + MEDPAR_BENE_IP_DDCTBL_AMT (MedPAR Beneficiary Inpatient Deductible Liability Amount) + MEDPAR_BENE_PTA_COINSRNC_AMT (MedPAR Beneficiary Part A Coinsurance Liability Amount) + MEDPAR_BENE_BLOOD_DDCTBL_AMT (MedPAR Beneficiary Blood Deductible Liability Amount) + MEDPAR_BENE_PRMRY_PYR_AMT (MedPAR Beneficiary Primary Payer Amount).

H_SNFEXP adds (MEDPAR_MDCR_PMT_AMT + MEDPAR_PASS_THRU_AMT + MEDPAR_BENE_IP_DDCTBL_AMT + MEDPAR_BENE_PTA_COINSRNC_AMT + MEDPAR_BENE_BLOOD_DDCTBL_AMT + MEDPAR_BENE_PRMRY_PYR_AMT) until all SNF expenditures for an individual have been totaled for the year.

H_HHAVST Number of HHA Covered Visits

Number of times for the year that a HHA covered service or procedure was performed.

Type: Numeric **Width:** 8

Possible Values:

Blank (No Home Health Agency claims data),
0 – 99999999* visits

Source:

Home Health Agency Standard Analytical File (SAF) - LINK_NUM (NCH Segment Link Number)

Home Health Agency SAF - HHREVCNT (HHA Revenue Center Code Count)

Home Health Agency SAF - RVCNTR01 – RVCNTR45 (HHA Revenue Center Code)

Home Health Agency SAF - RVUNT01 – RVUNIT45 (HHA Revenue Center Unit Count)

Usage Notes:

*Over 99% of the values for H_HHAVST are within 0-999. There are a small number of cases with values outside of this range. H_HHAVST values greater than 999 may be due clerical or data entry error in the HHA claims files. Researchers should consider dropping cases with H_HHAVST values greater than 999 from their analysis.

An individual may have one or more HHA claims for the year, which in turn, may be made up of one or more HHA segment records. HHA segment records share an identical LINK_NUM (NCH Segment Link Number). Within each HHA segment record, up to 45 occurrences of revenue center information may be present (RVCNTR01 – RVCNTR45).

The calculation of H_HHAVST requires the evaluation of each occurrence of RVCNTR** (Revenue Center Code) based on the number stored in HHREVCNT (HHA Revenue Center Code Count). For example, if HHREVCNT = 10 then the first 10 occurrences of Revenue Center Code (RVCNTR01 – RVCNTR10) must be evaluated.

When the second and third positions of RVCNTR** equals ‘42’, ‘43’, ‘44’, ‘45’, ‘47’, ‘55’, ‘56’ or ‘57’ then H_HHAVST equals the corresponding RVUNT** (Revenue Center Unit Count). For example, if RVCNTR05 = ‘0**42**1’, then H_HHAVST equals RVUNT05.

If multiple occurrences of RVCNTR** (second and third positions) equals ‘42’, ‘43’, ‘44’, ‘45’, ‘47’, ‘55’, ‘56’ or ‘57’ then H_HHAVST adds each corresponding RVUNT** until all corresponding RVUNT** occurrences have been totaled for the year.

H_HHAVST adds each applicable RVUNT** for HHA claims (including one or more segment records) until all HHA covered visits for an individual have been totaled for the year.

** Represents values ‘01’ thru ‘45’.

H_HHACCH HHA Covered Charges

Total covered charges (rounded to whole dollars) for the year for specific HHA accommodations and services prior to the reduction for the deductible and coinsurance amounts and prior to adjustment for the cost of services provided.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Home Health Agency claims data),
0 – 999999

Source:

Home Health Agency SAF - LINK_NUM (NCH Segment Link Number)

Home Health Agency SAF - HHREVCNT (HHA Revenue Center Code Count)

Home Health Agency SAF - RVCNTR01 – RVCNTR45 (HHA Revenue Center Code)

Home Health Agency SAF - RVCHRG01 – RVCHRG45 (HHA Revenue Center Total Charge Amount)

Usage Notes:

An individual may have one or more HHA claims for the year, which in turn, may be made up of one or more HHA segment records. HHA segment records share an identical LINK_NUM (NCH Segment Link Number). Within each HHA segment record, up to 45 occurrences of revenue center information may be present (RVCNTR01 – RVCNTR45).
The calculation of H_HHACCH requires the evaluation of each occurrence of RVCNTR** (Revenue Center Code) based on the number stored in HHREVCNT (HHA Revenue Center Code Count). For example, if HHREVCNT = 10 then the first 10 occurrences of Revenue Center Code (RVCNTR01 – RVCNTR10) must be evaluated.

When the second and third positions of RVCNTR** equals ‘42’, ‘43’, ‘44’, ‘45’, ‘47’, ‘55’, ‘56’ or ‘57’ then H_HHACCH equals the corresponding RVCHRG** (Revenue Center Total Charge Amount). For example, if RVCNTR05 = ‘0**42**1’, then H_HHACHRG equals RVCHRG05.

If multiple occurrences of RVCNTR** (second and third positions) equals ‘42’, ‘43’, ‘44’, ‘45’, ‘47’, ‘55’, ‘56’ or ‘57’ then H_HHACCH adds each

corresponding RVCHRG** until all corresponding RVCHRG** occurrences have been totaled for the year.

H_HHACCH adds each applicable RVCHRG** for HHA claims (including one or more segment records) until all HHA covered charges for an individual have been totaled for the year.

** Represents values '01' thru '45'.

H_HHACHO HHA Other Covered Charges

Total other covered charges (rounded to whole dollars) for the year for HHA accommodations and services prior to the reduction for the deductible and coinsurance amounts and prior to adjustment for the cost of services provided.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Home Health Agency claims data),
0 – 999999

Source:

Home Health Agency SAF - LINK_NUM (NCH Segment Link Number)

Home Health Agency SAF - HHREVCNT (HHA Revenue Center Code Count)

Home Health Agency SAF - RVCNTR01 – RVCNTR45 (HHA Revenue Center Code)

Home Health Agency SAF - RVCHRG01 – RVCHRG45 (HHA Revenue Center Total Charge Amount)

Usage Notes:

An individual may have one or more HHA claims for the year, which in turn, may be made up of one or more HHA segment records. HHA segment records share an identical LINK_NUM (NCH Segment Link Number). Within each HHA segment record, up to 45 occurrences of revenue center information may be present (RVCNTR01 – RVCNTR45).

The calculation of H_HHACHO requires the evaluation of each occurrence of RVCNTR** (Revenue Center Code) based on the number stored in HHREVCNT (HHA Revenue Center Code Count). For example, if HHREVCNT = 10 then the first 10 occurrences of Revenue Center Code (RVCNTR01 – RVCNTR10) must be evaluated.

When the RVCNTR** occurrence equals '0001', the corresponding RVCHRG** (Revenue Center Total Charge Amount) equals the "Total Covered Charges". H_HHACHO equals "Total Covered Charges" minus H_HHACCH (HHA Covered Charges).

H_HHACHO adds each calculated "HHA Other Covered Charges" ("Total Covered Charges" - H_HHACCH) for HHA claims (including one or more segment records) until all HHA other covered charges for an individual have been totaled for the year.

** Represents values '01' thru '45'.

H_HHRMBA HHA Reimbursement Part A

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund for the HHA services or procedures covered by Part A claim type records.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Home Health Agency claims data),
0 – 999999

Source:

Home Health Agency SAF - LINK_NUM (NCH Segment Link Number)

Home Health Agency SAF - RIC_CD (NCH Near Line Record Identification Code)

Home Health Agency SAF - PMT_AMT (Claim Payment Amount)

Usage Notes:

An individual may have one or more HHA claims for the year, which in turn, may be made up of one or more HHA segment records. HHA segment records share an identical LINK_NUM (NCH Segment Link Number).

Only "Part A" type claims are considered in the calculation of H_HHRMBA, determined by the value of 'V' or 'U' found in the RIC_CD (NCH Near Line Record Identification Code).

H_HHRMBA adds PMT_AMT (Claim Payment Amount) for HHA claims (including one or more segment records) until all HHA Part A claims reimbursements for an individual have been totaled for the year.

H_HHRMBB HHA Reimbursement Part B

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund for HHA services or procedures covered by Part B claim type records.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Home Health Agency claims data),
0 – 999999

Source:

Home Health Agency SAF - LINK_NUM (NCH Segment Link Number)

Home Health Agency SAF - RIC_CD (NCH Near Line Record Identification Code)

Home Health Agency SAF - PMT_AMT (Claim Payment Amount)

Usage Notes:

An individual may have one or more HHA claims for the year, which in turn, may be made up of one or more HHA segment records. HHA segment records share an identical LINK_NUM (NCH Segment Link Number).

Only "Part B" type claims are considered in the calculation of H_HHRMBB, determined by the value of 'W' found in the RIC_CD (NCH Near Line Record Identification Code).

H_HHRMBB continues to add PMT_AMT (Claim Payment Amount) for HHA claims (including one or more segment records) until all HHA Part B claims reimbursements for an individual have been totaled for the year.

H_HHAEXP HHA Total Expenditures

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund and by the beneficiary for HHA services or procedures.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Home Health Agency claims data),
0 – 999999

Source:

Home Health Agency SAF - LINK_NUM (NCH Segment Link Number)

Home Health Agency SAF - PMT_AMT (Claim Payment Amount)

Home Health Agency SAF - PRPAYAMT (NCH Primary Payer Claim Paid Amount)

Usage Notes:

An individual may have one or more HHA claims for the year, which in turn, may be made up of one or more HHA segment records. HHA segment records share an identical LINK_NUM (NCH Segment Link Number).

H_HHAEXP adds PMT_AMT (Claim Payment Amount) + PRPAYAMT (NCH Primary Payer Claim Paid Amount) for HHA claims (including one or more segment records) until all HHA expenditures for an individual have been totaled for the year.

H_HSDAYS Hospice Covered Days

Total number of covered days of hospice care for the year. Includes full days, coinsurance days and lifetime reserve days.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Hospice claims data),
1 – 999 days

Source: Hospice SAF - UTIL_DAY (Claim Utilization Day Count)

Usage Notes:

An individual may have one or more hospice claims for the year. There is only one hospice segment record per claim.

H_HSDAYS adds UTIL_DAY (Claim Utilization Day Count) until all hospice covered days for an individual have been totaled for the year.

H_HSTCHG Hospice Charges

Total covered and non-covered hospice charges (rounded to whole dollars) for the year for all accommodations and services prior to the reduction for the deductible and coinsurance amounts and prior to adjustment for the cost of services provided.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Hospice claims data),
1 – 999999

Source:

Hospice SAF - HSREVCNT (Revenue Center Code Count)

Hospice SAF - RVCNTR01 – RVCNTR45 (Revenue Center Code)

Hospice SAF - RVCHRG01 – RVCHRG45 (Revenue Center Total Charge Amount)

Usage Notes:

An individual may have one or more hospice claims in for the year. There is only one hospice segment record per claim. Within each hospice segment record, up to 45 occurrences of revenue center information may be present (RVCNTR01 – RVCNTR45).

The calculation of H_HSTCHG requires the evaluation of each occurrence of RVCNTR** (Revenue Center Code) based on the number stored in HSREVCNT (Revenue Center Code Count). For example, if HSREVCNT = 10 then the first 10 occurrences of Revenue Center Code (RVCNTR01 – RVCNTR10) must be evaluated.

When the RVCNTR** occurrence equals '0001', H_HSTCHG equals the corresponding RVCHRG** (Revenue Center Total Charge Amount). For example, if RVCNTR05 = '0001', then H_HSTCHG equals RVCHRG05.

H_HSTCHG adds RVCHRG** (where RVCNTR** = '0001') until all hospice charges for an individual have been totaled for the year.

** Represents values '01' thru '45'.

H_HSREIM Hospice Reimbursement

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund for hospice services covered by claim records.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Hospice claims data),
0 – 999999

Source: Hospice SAF - PMT_AMT (Claim Payment Amount)

Usage Notes:

An individual may have one or more hospice claims for the year. There is only one hospice segment record per claim.

H_HSREIM adds PMT_AMT (Claim Payment Amount) until all hospice reimbursements for an individual have been totaled for the year.

H_HSEXP Hospice Total Expenditures

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund and by the beneficiary for hospice services covered by claim records.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Hospice claims data),
0 – 999999

Source:

Hospice SAF - PMT_AMT (Claim Payment Amount)

Hospice SAF - RVBLD01 - RVBLD45 (Revenue Center Blood Deductible Amount)

Hospice SAF - RVDTBL01 - RVDTBL45 (Revenue Center Cash Deductible Amount)

Hospice SAF - WGDJ01 - WGDJ45 (Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount)

Hospice SAF - PRPAYAMT (NCH Primary Payer Claim Paid Amount)

Usage Notes:

An individual may have one or more hospice claims for the year. There is only one hospice segment record per claim.

H_HSREIM adds PMT_AMT (Claim Payment Amount) + (RVBLD01 - RVBLD45 (Revenue Center Blood Deductible Amount)) + (RVDTBL01 - RVDTBL45 (Revenue Center Cash Deductible Amount)) + (WGDJ01 - WGDJ45 (Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount)) + PRPAYAMT (NCH Primary Payer Claim Paid Amount) until all hospice expenditures for an individual have been totaled for the year.

H_OUTBIL Outpatient Claims

Total outpatient claims for the year.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Outpatient claims data),
1 – 999

Source: Outpatient SAF - LINK_NUM (NCH Segment Link Number)

Usage Notes:

An individual may have one or more outpatient claims for the year, which in turn, may be made up of one or more outpatient segment records. Outpatient segment records share an identical LINK_NUM (NCH Segment Link Number).

H_OUTBIL adds 1 for each for outpatient claim (including one or more segment records) until all outpatient claims for an individual have been totaled for the year.

H_OUTCHG Outpatient Charges

Total covered and non-covered outpatient charges (rounded to whole dollars) for the year for all accommodations and services prior to the reduction for the deductible and coinsurance amounts and prior to adjustment for the cost of services provided.

Type: Numeric **Width:** 7 **Format:** $$$$$$$

Possible Values:

Blank (No Outpatient claims data),
0 – 9999999

Source:

Outpatient SAF - LINK_NUM (NCH Segment Link Number)

Outpatient SAF - OPREVCNT (Revenue Center Code Count)

Outpatient SAF - RVCNTR01 – RVCNTR45 (Revenue Center Code)

Outpatient SAF - RVCHRG01 – RVCHRG45 (Revenue Center Total Charge Amount)

Usage Notes:

An individual may have one or more outpatient claims for the year, which in turn, may be made up of one or more outpatient segment records. Outpatient segment records share an identical LINK_NUM (NCH Segment Link Number). Within each outpatient segment record, up to 45 occurrences of revenue center information may be present (RVCNTR01 – RVCNTR45).

The calculation of H_OUTCHG requires the evaluation of each occurrence of RVCNTR** (Revenue Center Code) based on the number stored in OPREVCNT (Revenue Center Code Count). For example, if OPREVCNT = 10 then the first 10 occurrences of Revenue Center Code (RVCNTR01 – RVCNTR10) must be evaluated.

When the RVCNTR** occurrence equals ‘0001’, H_OUTCHG equals the corresponding RVCHRG** (Revenue Center Total Charge Amount). For example, if RVCNTR05 = ‘0001’, then H_OUTCHG equals RVCHRG05.

H_OUTCHG adds RVCHRG** (where RVCNTR** = '0001') for outpatient claims (including one or more segment records) until all outpatient charges for an individual have been totaled for the year.

** Represents values '01' thru '45'.

H_OUTRMB Outpatient Reimbursement

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund for outpatient services covered by claim records.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Outpatient claims data),
-99999 – 999999

Source:

Outpatient SAF - LINK_NUM (NCH Segment Link Number)

Outpatient SAF - PMT_AMT (Claim Payment Amount)

Usage Notes:

An individual may have one or more outpatient claims for the year, which in turn, may be made up of one or more outpatient segment records. Outpatient segment records share an identical LINK_NUM (NCH Segment Link Number).

H_OUTRMB adds PMT_AMT (Claim Payment Amount) for outpatient claims (including one or more segment records) until all outpatient reimbursements for an individual have been totaled the year.

H_OUTEXP Outpatient Total Expenditures

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund and by the beneficiary for outpatient services covered by claim records.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Outpatient claims data),
0 – 999999

Source:

Outpatient SAF - LINK_NUM (NCH Segment Link Number)

Outpatient SAF - PMT_AMT (Claim Payment Amount)

Outpatient SAF - PTB_COIN (NCH Beneficiary Part B Coinsurance Amount)

Outpatient SAF - PTB_DED (NCH Beneficiary Part B Deductible Amount)

Outpatient SAF - BLDDEDAM (NCH Beneficiary Blood Deductible Liability Amount)

Outpatient SAF - PRPAYAMT (NCH Primary Payer Claim Paid Amount)

Usage Notes:

An individual may have one or more outpatient claims for the year, which in turn, may be made up of one or more outpatient segment records. Outpatient segment records share an identical LINK_NUM (NCH Segment Link Number).

H_OUTRMB adds PMT_AMT (Claim Payment Amount) + PTB_COIN (NCH Beneficiary Part B Coinsurance Amount) + PTB_DED (NCH Beneficiary Part B Deductible Amount) + BLDDEDAM (NCH Beneficiary Blood Deductible Liability Amount) + PRPAYAMT (NCH Primary Payer Claim Paid Amount) for outpatient claims (including one or more segment records) until all outpatient expenditures for an individual have been totaled the year.

H_PHYCLM Physician Claims

Total non-institutional physician claims for the year.

Type: Numeric **Width:** 4

Possible Values:

Blank (No Carrier claims data),
1 – 9999

Source: Carrier SAF - LINK_NUM (NCH Segment Link Number)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

H_PHYCLM adds 1 for each physician claim (including one or more segment records) until all physician claims for an individual have been totaled for the year.

H_PHYLIN Physician Allowed Line Items

A count of the total non-institutional physician allowed line items for the year associated with all claims. Each line item represents a procedure, supply, product, or service provided by a physician. An individual physician claim can contain one or more line items. H_PHYLIN is a total count of all Medicare allowable procedures, supplies, products, and services provided by a physician for the year.

Type: Numeric **Width:** 4

Possible Values:

Blank (No Carrier claims data),
0 – 9999

Source:

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - CLINECNT (Carrier Claim Line Count)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number) and share the same count value in CLINECNT (Carrier Claim Line Count). For example, if there are four physician segment records with the same LINK_NUM, the value of "4" is stored in each of the four segment records CLINECNT.

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_PHYLIN. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_PHYLIN equals CLINECNT on any **ONE** of the physician segment records making up a single claim.

H_PHYLIN adds CLINECNT from **ONE** segment record per allowed claim until all physician allowed lines items for an individual have been totaled for the year.

H_PHYSCH Physician Submitted Charges

Total amount (rounded to whole dollars) of submitted physician charges for the year.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Carrier claims data),
0 – 999999

Source:

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Carrier SAF - LSBMTCHG (Line Submitted Charge Amount)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_PHYSCH. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_PHYSCH adds LSBMTCHG (Line Submitted Charge Amount) for allowed claims (including one or more segment records) until all physician submitted charges for an individual have been totaled for the year.

H_PHYACH Physician Allowed Charges

Total amount (rounded to whole dollars) of allowed physician charges for the year for service on non-institutional claims.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Carrier claims data),
0 – 999999

Source:

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_PHYACH. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_PHYACH adds LALOWCHG (Line Allowed Charge Amount) for allowed claims (including one or more segment records) until all physician allowed charges for an individual have been totaled for the year.

H_PHYRMB Physician Reimbursement

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund for non-institutional physician services covered by the claim record.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Carrier claims data),
0 – 999999

Source:

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Carrier SAF - LINEPMT (Line NCH Payment Amount)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_PHYRMB. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_PHYRMB adds LINEPMT (Line NCH Payment Amount) for allowed claims (including one or more segment records) until all physician reimbursements for an individual have been totaled for the year.

H_PHYEXP Physician Total Expenditures

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund and by the beneficiary for non-institutional physician services covered by the claim record.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Carrier claims data),
0 – 999999

Source:

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Carrier SAF - LINEPMT (Line NCH Payment Amount)

Carrier SAF - LDEDAMT (Line Beneficiary Part B Deductible Amount)

Carrier SAF - LPRPDAMT (Line Beneficiary Primary Payer Paid Amount)

Carrier SAF - COINAMT (Line Coinsurance Amount)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_PHYEXP. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_PHYEXP adds LINEPMT (Line NCH Payment Amount) + LDEDAMT (Line Beneficiary Part B Deductible Amount) + LPRPDAMT (Line Beneficiary Primary Payer Paid Amount) + COINAMT (Line Coinsurance Amount) for allowed claims (including one or more segment records) until all physician expenditures for an individual have been totaled for the year.

H_PMTVST Physician Office Visits

A count of the total number of office visits for the year made to a non-institutional physician provider.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Carrier claims data),
0 – 999 visits

Source:

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Carrier SAF - HCPCS_CD (Line HCPCS Code)

Carrier SAF - SRVC_CNT (Line Service Count)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_PMTVST. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the

PRCNGIND equals “R” or “S” and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

In addition, only segments identified as “visit” segments are considered in the calculation of H_PMTVST. Visit segments are identified by HCPCS_CD (Line HCPCS Code) values of “90000” thru “90090”, “M0001” thru “M0009”, and “99201” thru “99215”.

H_PMTVST adds SRVC_CNT (Line Service Count) for all visit segments of allowed claims (including one or more segment records) until all physician office visits for an individual have been totaled for the year.

H_PMTCHO Physician Office Visit Charges

Total amount (rounded to whole dollars) of allowed physician charges for the year associated with office visits.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Carrier claims data),
0 – 999999

Source:

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Carrier SAF - HCPCS_CD (Line HCPCS Code)

Usage Notes:

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_PMTCHO. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

In addition, only segments identified as "visit" segments are considered in the calculation of H_PMTCHO. Visit segments are identified by HCPCS_CD (Line HCPCS Code) values of "90000" thru "90090", "M0001" thru "M0009", and "99201" thru "99215".

H_PMTCHO adds LALOWCHG (Line Allowed Charge Amount) for all visit segments of allowed claims (including one or more segment records) until all physician office visit charges for an individual have been totaled for the year.

H_ERVST Emergency Room Visits

A count of the total number of emergency room visits for the year.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Inpatient hospital, Carrier, and Outpatient claims data),
1 – 999 visits

Source:

MedPAR File - MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator)

MedPAR File - MEDPAR_ER_CHRG_AMT (MedPAR Emergency Room Charge Amount)

MedPAR File - MEDPAR_ER_CHRG_AMT (MedPAR Emergency Room Charge Amount)

MedPAR File - MEDPAR_ADMSN_DT (MedPAR Admission Date)

Outpatient SAF - LINK_NUM (NCH Segment Link Number)

Outpatient SAF - RVCNTR01 – RVCNTR45 (Revenue Center Code)

Outpatient SAF - FAC_TYPE (Claim Facility Type Code)

Outpatient SAF - FREQ_CD (Claim Frequency Code)

Outpatient SAF - TYPESRVC (Claim Service Classification Type Code)

Outpatient SAF - FROM_DT (Claim From Date)

Carrier SAF - LINK_NUM (NCH Segment Link Number)

Carrier SAF - EXPNSDT1 (Line First Expense Date)

Carrier SAF - PRCNGIND (Line Processing Indicator Code)

Carrier SAF - LALOWCHG (Line Allowed Charge Amount)

Carrier SAF - HCPCS_CD (Line HCPCS Code)

Carrier SAF - SRVC_CNT (Line Service Count)

Carrier SAF - FROM_DT (Claim From Date)

Usage Notes:

H_ERVST adds 1 for each for emergency room (ER) visit until all ER visits for an individual have been totaled for the year.

ER visits can be recorded in the MedPAR File, Outpatient SAF, or Carrier SAF.

MedPAR File (ER visits with an admission to the hospital):

An individual may have one or more inpatient stay records for the year.

A MedPAR claims record is considered an inpatient stay if the MEDPAR_SS_LS_SNF_IND_CD (MedPAR Short Stay/Long Stay/SNF Indicator) equals “L” or “S”.

H_ERVST adds 1 for each MedPAR claims record with MEDPAR_ER_CHRG_AMT (MedPAR Emergency Room Charge Amount) greater than 0.

Outpatient SAF (ER visits without an admission to the hospital):

An individual may have one or more outpatient claims for the year, which in turn, may be made up of one or more outpatient segment records. Outpatient segment records share an identical LINK_NUM (NCH Segment Link Number).

Only segments identified as ER visit segments are considered in the calculation of H_ERVST. ER visit segments are identified by RVCNTR01 – RVCNTR45 (Revenue Center Code) values of "0450" thru "0459" when FAC_TYPE (Claim Facility Type Code) equals "1" (Hospital) and FREQ_CD (Claim Frequency Code) equals "0" thru "9" (Initial, Interim, Final, Late, or Replacement) and TYPESRVC (Claim Service Classification Type Code) equals "3" (Outpatient).

Carrier SAF**:**

An individual may have one or more physician claims for the year, which in turn, may be made up of one or more physician segment records. Physician segment records making up a single physician claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_ERVST. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals "A" or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

In addition, only segments identified as ER visit segments are considered in the calculation of H_ERVST. ER visit segments are identified by HCPCS_CD (Line HCPCS Code) values of "99280" thru "99286".

ER claims in the Carrier SAF may duplicate ER claims in MedPAR File and the Outpatient SAF. After H_ERVST was calculated, duplicate claims were eliminated based on the claims admission date:
MedPAR File - MEDPAR_ADMSN_DT (MedPAR Admission Date)
Outpatient SAF - FROM_DT (Claim From Date)
Carrier SAF - FROM_DT (Claim From Date)

H_DMECLM Durable Medical Equipment (DME) Supplier Claims

A count of the total number of DME claims for the year made to a regional carrier.

Type: Numeric **Width:** 4

Possible Values:

Blank (No Durable Medical Equipment claims data),
1 – 9999 claims

Source:

Durable Medical Equipment (DME) File - LINK_NUM (NCH Segment Link Number)

Usage Notes:

An individual may have one or more DME claims for the year, which in turn, may be made up of one or more DME segment records. DME segment records making up a single DME claim share an identical LINK_NUM (NCH Segment Link Number).

H_DMECLM adds 1 for each DME claim until all Durable Medical Equipment Supplier claims (including one or more segment records) for an individual have been totaled for the year.

H_DMELIN DME Allowed Line Items

A count of the total allowed DME line items processed by a regional carrier for the year. Each line item represents a procedure, supply, product, or service provided by a DME regional carrier. An individual DME regional claim can contain one or more line items. H_DMELIN is a total count of all Medicare allowable procedures, supplies, products, and services provided by a DME regional carrier for the year.

Type: Numeric **Width:** 4

Possible Values:

Blank (No Durable Medical Equipment claims data),
0 – 9999

Source:

Durable Medical Equipment (DME) File - LINK_NUM (NCH Segment Link Number)

Durable Medical Equipment (DME) File - EXPNSDT1 (Line First Expense Date)

Durable Medical Equipment (DME) File - DLINECNT (DME Claim Line Count)

Durable Medical Equipment (DME) File - PRCNGIND (Line Processing Indicator Code)

Durable Medical Equipment (DME) File - LALOWCHG (Line Allowed Charge Amount)

Usage Notes:

An individual may have one or more DME claims for the year, which in turn, may be made up of one or more DME segment records. DME segment records making up a single DME claim share an identical LINK_NUM (NCH Segment Link Number) and share the same count value in DLINECNT (DME Claim Line Count). For example, if there are four DME segment records with the same LINK_NUM, the value of "4" is stored in each of the four segment records DLINECNT.

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_DMELIN. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals 'A' or if the

PRCNGIND equals “R” or “S” and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_DMELIN equals DLINECNT on any **ONE** of the DME segment records making up a single claim.

H_DMELIN adds DLINECNT from **ONE** segment record per allowed claim until all DME allowed line items for an individual have been totaled for the year.

H_DMESCH DME Submitted Charges

Total amount (rounded to whole dollars) of DME charges submitted to a regional carrier for the year.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Durable Medical Equipment claims data),
0 – 999999

Source:

Durable Medical Equipment (DME) File - LINK_NUM (NCH Segment Link Number)

Durable Medical Equipment (DME) File - EXPNSDT1 (Line First Expense Date)

Durable Medical Equipment (DME) File - PRCNGIND (Line Processing Indicator Code)

Durable Medical Equipment (DME) File - LALOWCHG (Line Allowed Charge Amount)

Durable Medical Equipment (DME) File - LSBMTCHG (Line Submitted Charge Amount)

Usage Notes:

An individual may have one or more DME claims for the year, which in turn, may be made up of one or more DME segment records. DME segment records making up a single DME claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_DMESCH. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals 'A' or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_DMESCH adds LSBMTCHG (Line Submitted Charge Amount) for allowed claims (including one or more segment records) until all DME submitted charges for an individual have been totaled for the year.

H_DMEACH DME Allowed Charges

Total amount of allowed DME charges processed by DME regional carriers for the year.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Durable Medical Equipment claims data),
0 – 999999

Source:

Durable Medical Equipment (DME) File - LINK_NUM (NCH Segment Link Number)

Durable Medical Equipment (DME) File - EXPNSDT1 (Line First Expense Date)

Durable Medical Equipment (DME) File - PRCNGIND (Line Processing Indicator Code)

Durable Medical Equipment (DME) File - LALOWCHG (Line Allowed Charge Amount)

Usage Notes:

An individual may have one or more DME claims for the year, which in turn, may be made up of one or more DME segment records. DME segment records making up a single DME claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are

considered in the calculation of H_DMEACH. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals 'A' or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_DMEACH adds LALOWCHG (Line Allowed Charge Amount) for allowed claims (including one or more segment records) until all DME allowed charges for an individual have been totaled for the year.

H_DMERMB DME Reimbursement

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund for DME services covered by the claim record as processed by the regional carrier.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Durable Medical Equipment claims data),
0 – 999999

Source:

Durable Medical Equipment (DME) File - LINK_NUM (NCH Segment Link Number)

Durable Medical Equipment (DME) File - EXPNSDT1 (Line First Expense Date)

Durable Medical Equipment (DME) File - PRCNGIND (Line Processing Indicator Code)

Durable Medical Equipment (DME) File - LALOWCHG (Line Allowed Charge Amount)

Durable Medical Equipment (DME) File - LINEPMT (Line NCH Payment Amount)

Usage Notes:

An individual may have one or more DME claims for the year, which in turn, may be made up of one or more DME segment records. DME segment records making up a single DME claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_DMERMB. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals 'A' or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_DMERMB adds LINEPMT (Line NCH Payment Amount) for allowed claims (including one or more segment records) until all DME reimbursements for an individual have been totaled for the year.

H_DMEEXP DME Total Expenditures

Amount of payment (rounded to whole dollars) for the year made from the Medicare trust fund and by the beneficiary for DME services covered by the claim record as processed by the regional carrier.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Carrier claims data),
0 – 999999

Source:

Durable Medical Equipment (DME) File - LINK_NUM (NCH Segment Link Number)

Durable Medical Equipment (DME) File - EXPNSDT1 (Line First Expense Date)

Durable Medical Equipment (DME) File - PRCNGIND (Line Processing Indicator Code)

Durable Medical Equipment (DME) File - LALOWCHG (Line Allowed Charge Amount)

Durable Medical Equipment (DME) File - LINEPMT (Line NCH Payment Amount)

Durable Medical Equipment (DME) File - LDEDAMT (Line Beneficiary Part B Deductible Amount)

Durable Medical Equipment (DME) File - LPRPDAMT (Line Beneficiary Primary Payer Paid Amount)

Durable Medical Equipment (DME) File - COINAMT (Line Coinsurance Amount)

Usage Notes:

An individual may have one or more DME claims for the year, which in turn, may be made up of one or more DME segment records. DME segment records making up a single DME claim share an identical LINK_NUM (NCH Segment Link Number).

Only "allowed" claims where the year (the first 4 positions) of EXPNSDT1 (Line First Expense Date) is equal to FILE_YEAR4 (Medicare Claim Year) are considered in the calculation of H_DMERMB. A claim is considered allowed if the PRCNGIND (Line Processing Indicator Code) equals 'A' or if the PRCNGIND equals "R" or "S" and LALOWCHG (Line Allowed Charge Amount) is greater than 0.

H_DMEEXP adds LINEPMT (Line NCH Payment Amount) + LDEDAMT (Line Beneficiary Part B Deductible Amount) + LPRPDAMT (Line Beneficiary Primary Payer Paid Amount) + COINAMT (Line Coinsurance Amount) for allowed claims (including one or more segment records) until all DME expenditures for an individual have been totaled for the year.

H_PTDEVTS Number of Prescription Drug Events (PDEs)

Total number of beneficiary's prescription drug events for the year.

Type: Numeric **Width:** 3

Possible Values:

Blank (No Prescription Drug Event data),
1 – 999 Prescription Drug Events

Source:

Part D Prescription Drug Event (PDE) File

Usage Notes:

This variable is only available for Medicare claim years 2006-2007.

An individual may have one or more prescription drug event records for the year.

H_PTDEVTS adds 1 for each prescription drug event until all prescription drug events have been totaled for the year.

H_PDEGDC Gross Prescription Drug Cost

A summation (rounded to whole dollars) for the year of the total payments made by the Medicare Part D plan, the beneficiary, and qualified third parties for prescription drugs. Includes patient payment amounts, plan reported low-income cost-sharing subsidies, qualified third party payments, Part D plan payments for standard and non-standard benefits, and any additional payments that reduced the beneficiary's liability.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Prescription Drug Event data),
1 – 999999

Source:

Part D Prescription Drug Event (PDE) File - PTNT_PAY_AMT (Patient Pay Amount)

Part D Prescription Drug Event (PDE) File - LICS_AMT (Low Income Cost Sharing Subsidy Amount)

Part D Prescription Drug Event (PDE) File - OTHR_TROOP_AMT (Other True Out-of-Pocket (TrOOP) Amount)

Part D Prescription Drug Event (PDE) File - PLRO_AMT (Patient Liability Reduction Due to Other Payer Amount)

Part D Prescription Drug Event (PDE) File - CVRD_D_PLAN_PD_AMT (Covered D Plan Paid Amount)

Part D Prescription Drug Event (PDE) File - NCVRD_PLAN_PD_AMT (Non-Covered Plan Paid Amount)

Usage Notes:

This variable is only available for Medicare claim years 2006-2007.

An individual may have one or more prescription drug event records for the year.

H_PDEGDC equals PTNT_PAY_AMT (Patient Pay Amount) + LICS_AMT (Low Income Cost Sharing Subsidy Amount) + OTHR_TROOP_AMT (Other True Out-of-Pocket (TrOOP) Amount) + PLRO_AMT (Patient Liability

Reduction Due to Other Payer Amount) + CVRD_D_PLAN_PD_AMT (Covered D Plan Paid Amount) + NCVRD_PLAN_PD_AMT (Non-Covered Plan Paid Amount).

H_PDEGDC adds (PTNT_PAY_AMT + LICS_AMT + OTHR_TROOP_AMT + PLRO_AMT + CVRD_D_PLAN_PD_AMT + NCVRD_PLAN_PD_AMT) until all prescription drug payments for an individual have been totaled for the year.

H_PDETOC Prescription Drug True Out-of-Pocket Cost (TrOOP)

The total payments (rounded to whole dollars) for prescription drugs made by the beneficiary and qualified third parties for the year.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Prescription Drug Event data),
0 – 999999

Source:

Part D Prescription Drug Event (PDE) File - PTNT_PAY_AMT (Patient Pay Amount)

Part D Prescription Drug Event (PDE) File - LICS_AMT (Low Income Cost Sharing Subsidy Amount)

Part D Prescription Drug Event (PDE) File - OTHR_TROOP_AMT (Other True Out-of-Pocket (TrOOP) Amount)

Usage Notes:

This variable is only available for Medicare claim years 2006-2007.

An individual may have one or more prescription drug event records for the year.

H_PDETOC equals PTNT_PAY_AMT (Patient Pay Amount) + LICS_AMT (Low Income Cost Sharing Subsidy Amount) + OTHR_TROOP_AMT (Other True Out-of-Pocket (TrOOP) Amount).

H_PDETOC adds (PTNT_PAY_AMT + LICS_AMT + OTHR_TROOP_AMT) until all TrOOP prescription drug payments for an individual have been totaled for the year.

H_ BENRES Beneficiary's Prescription Drug Payment Responsibility

The total payments (rounded to whole dollars) for prescription drugs made by the beneficiary, qualified third parties, and non-TrOOP-eligible payers, such as group health plans, worker's compensation, and governmental programs (e.g. VA, TRICARE) for the year.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Prescription Drug Event data),
0 – 999999

Source:

Part D Prescription Drug Event (PDE) File - PTNT_PAY_AMT (Patient Pay Amount)

Part D Prescription Drug Event (PDE) File - LICS_AMT (Low Income Cost Sharing Subsidy Amount)

Part D Prescription Drug Event (PDE) File - OTHR_TROOP_AMT (Other True Out-of-Pocket (TrOOP) Amount)

Part D Prescription Drug Event (PDE) File - PLRO_AMT (Patient Liability Reduction Due to Other Payer Amount)

Usage Notes:

This variable is only available for Medicare claim years 2006-2007.

An individual may have one or more prescription drug event records for the year.

H_ BENRES equals PTNT_PAY_AMT (Patient Pay Amount) + LICS_AMT (Low Income Cost Sharing Subsidy Amount) + OTHR_TROOP_AMT (Other True Out-of-Pocket (TrOOP) Amount) + PLRO_AMT (Patient Liability Reduction Due to Other Payer Amount).

H_ BENRES adds (PTNT_PAY_AMT + LICS_AMT + OTHR_TROOP_AMT + PLRO_AMT) until all of a beneficiary's prescription drug payment responsibilities have been totaled for the year.

H_PTDNET Net Amount Paid by Part D Plan

The total payments (rounded to whole dollars) made for prescription drugs by the Medicare Part D plan (including standard and non-standard benefits) for the year.

Type: Numeric **Width:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Prescription Drug Event data),
-99999 – 999999

Source:

Part D Prescription Drug Event (PDE) File - CVRD_D_PLAN_PD_AMT (Covered D Plan Paid Amount)

Part D Prescription Drug Event (PDE) File - NCVRD_PLAN_PD_AMT (Non-Covered Plan Paid Amount)

Usage Notes:

This variable is only available for Medicare claim years 2006-2007.

An individual may have one or more prescription drug event records for the year.

CVRD_D_PLAN_PD_AMT (Covered D Plan Paid Amount) does not include supplemental drugs, supplemental cost-sharing amounts, over-the-counter drugs, or non-Part D drugs funded by Part C rebates.

NCVRD_PLAN_PD_AMT (Non-Covered Plan Paid Amount) includes amounts paid for all over-the-counter drugs, enhanced alternative drugs, and enhanced alternative cost-sharing amounts.

H_PTDNET equals CVRD_D_PLAN_PD_AMT (Covered D Plan Paid Amount) + NCVRD_PLAN_PD_AMT (Non-Covered Plan Paid Amount).

H_PTDNET adds (CVRD_D_PLAN_PD_AMT + NCVRD_PLAN_PD_AMT) until all prescription drug payments made by Part D plan for an individual have been totaled for the year.

Appendix A: Data Usage Issues regarding PUBLICID/SEQN/RESNUM

The data provided on the 1994-2005 NHIS, NHEFS, 1999-2004 NHANES, NHANES III, LSOA II and 2004 NNHS linked CMS Medicare files can be merged with the NCHS public use survey data files using the unique survey specific Public Identification number (PUBLICID/SEQN/RESNUM).

Note: At this time the linked Medicare data files are only available for research use through the NCHS restricted access data center (RDC). Approved RDC researchers may choose to provide their own analytic files created from public use survey files to the RDC. Therefore, it is important for researchers to include survey specific Public Identification number on any analytic files sent to the RDC. The RDC will merge data (using PUBLICID, SEQN or RESNUM) from the linked CMS Medicare files to the analyst's file. The merged file will be held at the RDC and made available for analysis. Information on how to identify and/or construct the NCHS survey specific PUBLICID, SEQN or RESNUM is provided below.

I. National Health Interview Survey (NHIS)

On the NHIS surveys, researchers need to construct the NHIS public id from the following variables. The number and public-use location varies by NHIS survey year.

NHIS 1994

Item	Public-use Location	Length	Description
Year (2 digit)	3-4	2	Year of interview
Quarter	5	1	Calendar quarter of interview
PSU	6-8	3	Random recode of PSU #
Week	9-10	2	Week of interview within quarter
Segment	11-12	2	Segment number
Household	13-14	2	Household number within quarter
Person number	15-16	2	Person number within household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

NHIS 1995, 1996

Item	Public-use Location	Length	Description
Year (2 digit)	3-4	2	Year of interview
Household ID	5-14	10	Household ID number
Person number	15-16	2	Person number within Household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

NHIS 1997-2003

Item	Public-use Location	Length	Description
Year (4 digit)	3-6	4	Year of interview
Household Serial #	7-12	6	Household serial number
Person number	15-16	2	Person number within Household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

NHIS 2004, 2005

Item	Public-use Location	Length	Description
Year (4 digit)	3-6	4	Year of interview
Household serial #	7-12	6	Household serial number
Family sequence #	13-14	2	Family number
Person sequence #	15-16	2	Person number

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

II. NHANES I Epidemiologic Follow-up Study NHEFS

Item	Length	Description
SEQN	5	Participant identification number

All of the NHEFS public-use data files are linked with the common survey participant identification number (SEQN). Merging information from multiple NHEFS Files to the NHEFS-CMS linked files using this variable ensures that the appropriate information for each survey participant is linked correctly.

III. National Health and Nutrition Examination Survey (NHANES)

Item	Length	Description
SEQN	5	Participant identification number

All of the NHANES public-use data files are linked with the common survey participant identification number (SEQN). Merging information from multiple NHANES Files to the NHANES-CMS linked files using this variable ensures that the appropriate information for each survey participant is linked correctly

IV. Third National Health and Nutrition Examination Survey (NHANES III)

Item	Length	Description
SEQN	5	Participant identification number

All of the NHANES III public-use data files are linked with the common survey participant identification number (SEQN). Merging information from multiple NHANES III Files to the NHANES III-CMS linked files using this variable ensures that the appropriate information for each survey participant is linked correctly.

V. The Second Longitudinal Study of Aging (LSOA II)

On the LSOA II survey, researchers need to construct the LSOA II public id from the following variables.

LSOA II

Item	Public-use Location	Length	Description
Year	3-4	2	Year of interview
Quarter	5	1	Calendar quarter of interview
PSU	6-8	3	Random recode of PSU #
Week	9-10	2	Week of interview within quarter
Segment	11-12	2	Segment number
Household	13-14	2	Household number within quarter
Person number	15-16	2	Person number within household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

VI. 2004 National Nursing Home Survey (NNHS)

Item	Length	Description
RESNUM	6	Resident Record (Case) Number

All of the 2004 NNHS public-use data files are linked with the common resident record (case) number (RESNUM). Merging information from the 2004 NNHS Files to the 2004 NNHS-CMS linked files using this variable ensures that the appropriate information for each survey participant is linked correctly.