Summary Medicare Enrollment and Claims Files (1991-2000)

PUBLICID NCHS Public ID

Numeric identifier given by NCHS to allow for linkage between NCHS surveys and CMS files.

Type: Character **Width:** 14

Usage Notes:

See Appendix A for NCHS survey specific descriptions.

H_CLMYR Medicare Claim Year

Year in which Medicare claims were filed.

Type: Character **Width:** 4 **Format:** CCYY

Possible Values: 1991 – 2000

Usage Notes:

There is a separate data file for each year of Medicare coverage (1991-2000).

H_RACE Race

Race of the beneficiary.

Type: Character **Width:** 1

Possible Values:

0 = Unknown
1 = White
2 = Black
3 = Other
4 = Asian
5 = Hispanic
6 = North American Native
Blank = No Denominator File data, but other claims data available

Source: Denominator File - RACE_CD (Beneficiary Race Code)

Usage Notes:

H_RACE equals RACE_CD (Beneficiary Race Code).

The values reported for race may be different for each Medicare year.

H_DOD Date of Death

Date of death of the beneficiary.

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

Possible Values:

19910101-20011231
00000000 = Not dead

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

Usage Notes:

H_DOD equals DOD (Beneficiary Date of Death Code).

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

H_MEDSTAT Medicare Status Code

This field specifies the reason for the beneficiary's 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
Blank = No Denominator File data, but other claims data available

Source:

Denominator File - MEDICARE_STAT (Medicare Status Code)

Usage Notes:

ESRD - End Stage Renal Disease

H_MEDSTAT equals MEDICARE_STAT (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 H_CLMYR.

Analysts should be aware that disagreement between the Current Reason for Entitlement (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

This code specifies the reason 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
9 = Other termination

Source:

Denominator File - PART_A_TERM_CD (Beneficiary Part A Termination Code)

Usage Notes:

H_TERMPTA equals PART_A_TERM_CD (Beneficiary Part A Termination Code).

H_TERMPTB Part B Termination

This code specifies the reason 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
9 = Other termination

Source:

Denominator File - PART_B_TERM_CD (Beneficiary Part B Termination Code)

Usage Notes:

H_TERMPTB equals PART_B_TERM_CD (Beneficiary Part B Termination Code).

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_REAS_ENTITLEMENT (Current Reason for Entitlement)

Usage Notes:

H_CREC equals CURR_REAS_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 H_CLMYR.

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_REAS_ENTITLEMENT (Original Reason for Entitlement)

Usage Notes:

H_OREC equals ORIG_REAS_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:

Blank (No Denominator File data, but other claims data available),
1 – 12 months

Source:

Denominator File - MEDICARE_BUYIN01 – MEDICARE_BUYIN12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) for each year.

H_MDCOVRG adds 1 for each of the Medicare monthly entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) **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:

Blank (No Denominator File data, but other claims data available),
0 – 12 months

Source:

Denominator File - MEDICARE_BUYIN01 – MEDICARE_BUYIN12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) for each year.

H_MEDEPTA adds 1 for each of the Medicare monthly entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) 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:

Blank (No Denominator File data, but other claims data available),
0 – 12 months

Source:

Denominator File - MEDICARE_BUYIN01 – MEDICARE_BUYIN12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) for each year.

H_MEDEPTB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) 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:

Blank (No Denominator File data, but other claims data available),
0 – 12 months

Source:

Denominator File - MEDICARE_BUYIN01 – MEDICARE_BUYIN12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) for each year.

H_MDEPTAB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) 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:

Blank (No Denominator File data, but other claims data available),
0 – 12 months

Source:

Denominator File - MEDICARE_BUYIN01 – MEDICARE_BUYIN12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) for each year.

H_MEDSPTA adds 1 for each of the Medicare monthly entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) 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:

Blank (No Denominator File data, but other claims data available),
0 – 12 months

Source:

Denominator File - MEDICARE_BUYIN01 – MEDICARE_BUYIN12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) for each year.

H_MEDSPTB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) 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:

Blank (No Denominator File data, but other claims data available),
0 – 12 months

Source:

Denominator File - MEDICARE_BUYIN01 – MEDICARE_BUYIN12 (Medicare monthly entitlement/buy-in indicators)

Usage Notes:

There are 12 monthly occurrences of Medicare entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) for each year.

H_MDSPTAB adds 1 for each of the Medicare monthly entitlement/buy-in indicators (MEDICARE_BUYIN01 – MEDICARE_BUYIN12) equal to 'C'.

H_HMOENRL Total Months of HMO Enrollment

Total months of HMO enrollment for the year.

Type: Numeric **Width:** 2

Possible Values:

Blank (No Denominator File data, but other claims data available),
0 – 12 months

Source:

Denominator File - HMO_INDICATOR01 – HMO_INDICATOR12 (HMO monthly enrollment indicators)

Usage Notes:

There are 12 monthly occurrences of HMO enrollment indicators (HMO_INDICATOR01 – HMO_INDICATOR12) for each year.

H_HMOENRL adds 1 for each of the HMO monthly enrollment indicators (HMO_INDICATOR01 – HMO_INDICATOR12) **NOT** equal to '0'.

This variable provides information on whether a Medicare beneficiary received Medicare services as an enrollee in a group health maintenance organization. Information on health care services utilization will not be available for most Medicare beneficiaries who participate in Medicare HMO plans. Researchers should consider the implications of including managed care enrollees in the samples for analysis.

CMS generally does not receive claims data for Medicare beneficiaries who enroll in managed care plans (including private fee-for-service plans paid on a capitation basis). During the time covered by the linked database, enrollment in managed care increased from approximately 6% of beneficiaries in 1991 to 17% in 1999. A large number of managed care plans withdrew from Medicare beginning in 1999, resulting in a decrease in enrollment in 2000 to 16% of beneficiaries. In general, studies based on analysis of claims data should exclude managed care enrollees from their beneficiary samples. Additional information regarding analytic issues with the NCHS-CMS 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; No Denominator File data, but other claims data available

Source:

Denominator File - HMO_INDICATOR01 – HMO_INDICATOR12 (HMO monthly enrollment indicators)

Usage Notes:

There are 12 monthly occurrences of HMO enrollment indicators (HMO_INDICATOR01 – HMO_INDICATOR12) for each year.

H_HMOMNTH indicates the first month a value **NOT** equal to '0' or '9' appears in the HMO monthly enrollment indicators (HMO_INDICATOR01 – HMO_INDICATOR12) when H_CLMYR (Medicare Claim Year) equals '1991'.

H_HMOMNTH indicates the first month a value **NOT** equal to '0' appears in the HMO monthly enrollment indicators (HMO_INDICATOR01 – HMO_INDICATOR12) when H_CLMYR (Medicare Claim Year) equals '1992' through '2000'.

This variable provides information on the first month of the year a Medicare beneficiary received Medicare services as an enrollee in a group health

maintenance organization. Information on health care services utilization will not be available for most Medicare beneficiaries who participate in Medicare HMO plans. Researchers should consider the implications of including managed care enrollees in the samples for analysis.

CMS generally does not receive claims data for Medicare beneficiaries who enroll in managed care plans (including private fee-for-service plans paid on a capitation basis). During the time covered by the linked database, enrollment in managed care increased from approximately 6% of beneficiaries in 1991 to 17% in 1999. A large number of managed care plans withdrew from Medicare beginning in 1999, resulting in a decrease in enrollment in 2000 to 16% of beneficiaries. In general, studies based on analysis of claims data should exclude managed care enrollees from their beneficiary samples. Additional information regarding analytic issues with the NCHS-CMS 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_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 Hospital Stay claims data),
19910101 – 20001231

Source:

MedPAR Hospital Stay File - MEDPAR_DSCHRG_DT (MedPAR Discharge Date)

Usage Notes:

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

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 Hospital Stay claims data),
0 – 510

Source:

MedPAR Hospital Stay File - MEDPAR_DRG_CD (MedPAR DRG Code)

Usage Notes:

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

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 Hospital Stay claims data

Source:

MedPAR Hospital Stay 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.

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 Hospital Stay claims data),
1 – 99 stays

Source: MedPAR Hospital Stay File

Usage Notes:

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

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 Hospital Stay claims data),
0 – 999 days

Source:

MedPAR Hospital Stay File MEDPAR_UTLZTN_DAY_CNT (MedPAR Utilization Day Count)

Usage Notes:

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

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 Hospital Stay claims data),
0 – 9999999

Source:

MedPAR Hospital Stay 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.

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 Hospital Stay claims data),
0 – 9999999

Source:

MedPAR Hospital Stay 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.

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:** 6 **Format:** $$$$$$

Possible Values:

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

Source:

MedPAR Hospital Stay File - MEDPAR_MDCR_PMT_AMT (MedPAR Medicare Payment Amount)

MedPAR Hospital Stay 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.

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 Hospital Stay claims data),
0 – 99 days

Source:

MedPAR Hospital Stay 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.

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 Hospital Stay claims data),
0 – 99999

Source:

MedPAR Hospital Stay 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.

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_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 Skilled Nursing Facility File

Usage Notes:

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

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 Skilled Nursing Facility File - UTLZTN_DAY_CNT (MedPAR Utilization Day Count)

Usage Notes:

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

H_SNFDAY adds 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:** 6 **Format:** $$$$$$

Possible Values:

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

Source:

MedPAR Skilled Nursing Facility File - TOT_CHRG_AMT (MedPAR Total Charge Amount)

Usage Notes:

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

H_SNFCHG adds 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 Skilled Nursing Facility File - TOT_CVR_CHRG_AMT (MedPAR Total Covered Charge Amount)

Usage Notes:

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

H_SNFCCH adds 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 Skilled Nursing Facility File - MDCR_PMT_AMT (MedPAR Medicare Payment Amount)

MedPAR Skilled Nursing Facility File - PASS_THRU_AMT (MedPAR Total Pass Through Amount)

Usage Notes:

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

H_SNFRMB equals MDCR_PMT_AMT (MedPAR Medicare Payment Amount) + PASS_THRU_AMT (MedPAR Total Pass Through Amount).

H_SNFRMB adds (MDCR_PMT_AMT + 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 Skilled Nursing Facility File - 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.

H_SNFCDY adds 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 Skilled Nursing Facility File - 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.

H_SNFCAM adds 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_HHAVST Number of HHA Covered Visits

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

Type: Numeric **Width:** 4

Possible Values:

Blank (No Home Health Agency claims data),
0 – 9999 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:

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_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_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:** 6 **Format:** $$$$$$

Possible Values:

Blank (No Outpatient claims data),
0 – 999999

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_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 H_CLMYR (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 H_CLMYR (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 H_CLMYR (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 H_CLMYR (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_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 H_CLMYR (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 H_CLMYR (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_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 File (DMERC) - 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 DME regional allowed line items 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 File (DMERC) - LINK_NUM (NCH Segment Link Number)

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

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

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

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

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

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

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

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

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

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

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

Usage Notes:

An individual may have one or more DME claims for then 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 H_CLMYR (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.

Appendix A: Data Usage Issues Regarding Public ID/SEQN

Data Usage Issues regarding Public ID/SEQN

The data provided on the 1994-1998 NHIS, NHEFS, NHANES II, NHANES III, and LSOA III linked CMS Medicare files can be merged with the NCHS public use survey data files using the unique survey specific Public Identification number (PUBLIC ID/SEQN). 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 PUBLIC ID or SEQN) 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 PUBLIC ID or SEQN 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 1997-1998

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.

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. Second National Health and Nutrition Examination Survey (NHANES II)

Item	Length	Description
SEQN	5	Participant identification number

All of the NHANES II public-use data files are linked with the common survey participant identification number (SEQN). Merging information from multiple NHANES II Files to the NHANES II-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.