Restricted-use Linked NCHS-CMS Medicare Data
Outpatient Value Codes
DATE CREATED: 02FEB2017
Number of Variables: 11

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
SURVEY	NCHS SURVEY NAME	Char	20	-	
PUBLICID	NHIS PUBLIC USE ID	Char	14	ID	
SEQN	NHANES SAMPLE SEQUENCE NUMBER (PUBLIC ID)	Num	8	ID	
RESNUM	NNHS RESIDENT ID NUMBER (PUBLIC)	Num	8	ID	
PATNUM	Patient/Discharge Record (Case) Number in public-use file	Num	8	ID	
FILE_YEAR4	Beneficiary Enrollment Reference Year (YYYY)	Num	4	1999-2013	
NCHS_CLM_ID	NCHS CLAIM ID	Num	8		
NCH_CLM_TYPE_CD	NCH Claim Type Code	Char	2	40	Outpatient claim
RLT_VAL_CD_SEQ	Claim Related Value Code Sequence	Char	2	-	
CLM_VAL_CD	Claim Value Code	Char	2	**OTHER**	Miscoded
				01	Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
				02	Hospital Has No Semi-Private Rooms - Entering this code requires $0.00 amount.
				04	Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
				05	Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
				06	Medicare blood deductible - Total cash blood deductible (Part A blood deductible).

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
				07	Medicare cash deductible (term 9/30/93) reserved for national assignment.
				08	Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)
				09	Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission. (not stored in NCH until 2/93)
				10	Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years. (in NCH until 2/93)
				12	Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed condition
				13	Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed condit
				14	That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider cla
				15	That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditio
				16	That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed
				17	Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment
				18	Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by t
				19	Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS
				21	Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
				22	Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
				23	Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
				24	Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
				25	Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Perio

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				28	Offset to the Patient (Payment Amount - Dental Services) - Dental services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
				29	Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropratic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Cove
				31	Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.
				32	Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination. (eff. 4/1/2003)
				33	Offset to the Patient Payment Amount (Podiatric Services) -- Podiatric services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
				34	Offset to the Patient Payment Amount (Medical Services) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
				35	Offset to the Patient Payment Amount (Health Insurance Premiums) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
				37	Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient. (eff 10/93)
				38	Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)
				39	Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)
				40	New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not
				41	Amount is that portion of a payment from higher priority BL program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed con
				42	Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional
				43	Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on t
				44	Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the received amount is less than charges, a Medi
				45	Accident Hour - The hour the accident occurred that necessitated medical treatment.

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				46	Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care. (eff 10/93)
				47	Any liability insurance - Amount is that portion from a higher priority liability insurance made on behalf of Medicare bene the provider is applying to Medicare covered services on this bill. (Eff 9/9
				48	Hemoglobin reading - The patient's most recent hemoglobin reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during
				49	Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing
				50	Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.
				51	Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
				52	Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.
				53	Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.
				54	New birth weight in grams - Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of '4' and on other claims as required by law.
				55	Eligibility Threshold for Charity Care - code identifies the corresponding value amount at which a health care facility determines the eligibility threshold of charity care.
				56	Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
				57	Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.
				58	Arterial blood gas - Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth
				59	Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth mo
				60	HHA branch MSA - MSA in which HHA branch is located.
				61	Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of th

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				66	Medicare Spend-down Amount -- The dollar amount that was used to meet th4e recipient's spend-down liability for this claim.
				67	Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home). (eff. 10/97)
				68	EPO drug - Number of units of EPO administered relating to the billing period.
				69	Reserved for national assignment
				70	Interest amount - (Providers do not report this.) Report the amount applied to this bill.
				71	Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
				72	Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.
				73	Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.
				74	Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.
				76	Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimite
				77	New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (incl
				78	Payer code - This codes is set aside for payer use only. Providers do not report these codes.
				79	Payer code - This code is set aside for payer use only. Providers do not report these codes.
				80	Reserved for state assignment.
				81	Reserved for state assignment.
				82	Reserved for state assignment.
				83	Reserved for state assignment.
				84	Reserved for state assignment.
				85	Reserved for state assignment.
				86	Reserved for state assignment.

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
				87	Reserved for state assignment.
				88	Reserved for state assignment.
				89	Reserved for state assignment.
				90	Reserved for state assignment.
				91	Reserved for state assignment.
				92	Reserved for state assignment.
				93	Reserved for state assignment.
				94	Reserved for state assignment.
				95	Reserved for state assignment.
				96	Reserved for state assignment.
				97	Reserved for state assignment.
				98	Reserved for state assignment.
				99	Reserved for state assignment.
				A0	Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)
				A1	Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the invovling the indicated payer. (eff. 10/93) - Prior value 07
				A2	Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
				A3	Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.
				A4	Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a pa
				A5	Covered self-administered drugs -- The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situatio
				A6	Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagn
				A7	Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

Variable Name	Variable Label (VAR)	VAR Type	VAR Length	Range of Values	Value Description
				A8	Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.
				A9	Patient Height - Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
				AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the ind
				AB	Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer (eff. 10/2003).
				B1	Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
				B2	Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
				B3	Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
				BA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the ind
				C1	Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
				C2	Coinsurance Payer C - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
				C3	Estimated Responsibility Payer C - The stop
				D3	Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.
				D4	Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial
				G8	Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08)
CLM_VAL_AMT	Claim Value Amount	Num	8		