

Medicare Post-Acute Care Utilization - IRF Supplemental Data Dictionary

Variable Name	Term Name	Definition
YEAR	Year	The year of data.
YEAR_TYPE	Year Type	Identifies if the data is for calendar year (CY) or fiscal year (FY).
SMRY_CTGRY	Summary Category	Identifies if the data is at the national, state, or provider level.
SRVC_CTGRY	Service Category	Identifies the PAC setting: HH, hospice, SNF, IRF, or LTCH.
STATE	State	The state where the provider is located, as reported in Provider of Services file. The fifty U.S. states, the District of Columbia, and Puerto Rico are reported by their postal abbreviation. Note for national level, no state is reported.
PRVDR_ID	Provider ID	The 6-digit CCN for the provider.
PRVDR_NAME	Facility Name	The provider name, as reported in the Provider of Services file.
PRVDR_CITY	City	The city where the provider is located, as reported in the Provider of Services file.
PRVDR_ZIP	ZIP	The provider's ZIP code, as reported in the Provider of Services file. Note, for state and national levels, ZIP code is not reported.
GRPNG	Grouping	This is the 4-character CMG.
GRPNG_DESC	Grouping Description	Describes the 4-character CMG.
BENE_DSTNCT_CNT	Distinct Beneficiaries	Number of unique Medicare beneficiaries with at least one paid claim in the calendar or fiscal year.
TOT_EPSD_STAY_CNT	Episode or Stay Count	The total counts of stays provided in the fiscal year.
TOT_SRVC_DAYS	Days of Service	Total count of covered days delivered by a provider in the FY.
AVG_CHRG_PER_BENE	Average Charge Per Beneficiary	Average of the Total Charge Amount per beneficiary. The Total Charge Amount is the total charges submitted by the provider.
AVG_ALOWD_AMT_PER_BENE	Average Allowed Amount Per Beneficiary	Average of the Medicare Allowed Amount per beneficiary. The Medicare Allowed Amount is the sum of the amount Medicare pays, the deductible and coinsurance amounts that the beneficiary is responsible for paying, and any amounts that a third party is responsible for paying. This applies only to the IRF Provider by CMG supplemental file.
AVG_PYMT_AMT_PER_BENE	Average Payment Amount Per Beneficiary	Average of the Total Medicare Payment Amount per beneficiary. The Total Medicare Payment Amount is the total amount that Medicare paid after deductible and coinsurance amounts have been deducted
AVG_STDZD_PYMT_AMT_PER_BENE	Average Standardized Payment Amount Per Beneficiary	Average of the Total Medicare Standardized Payment Amount per beneficiary. The Medicare Standardized Payment Amount is the total amount that Medicare paid adjusted for geographic differences in payment rates
AVG_CHRG_PER_STAY	Average Charge Per Stay	Average of the Total Charge Amount per Stay. The Total Charge Amount is the total charges submitted by the provider. This applies only to the IRF Provider by CMG supplemental file.

Medicare Post-Acute Care Utilization - IRF Supplemental Data Dictionary

Variable Name	Term Name	Definition
AVG_ALOWD_AMT_PER_STAY	Average Allowed Amount Per Stay	Average of the Medicare Allowed Amount per Stay. The Medicare Allowed Amount is the sum of the amount Medicare pays, the deductible and coinsurance amounts that the beneficiary is responsible for paying, and any amounts that a third party is responsible for paying. This applies only to the IRF Provider by CMG supplemental file.
AVG_PYMT_AMT_PER_STAY	Average Payment Amount Per Stay	Average of the Total Medicare Payment Amount per Stay. The Total Medicare Payment Amount is the total amount that Medicare paid after deductible and coinsurance amounts have been deducted. This applies only to the IRF Provider by CMG supplemental file.
AVG_STDZD_PYMT_AMT_PER_STAY	Average Standardized Payment Amount Per Stay	Average of the Total Medicare Standardized Payment Amount per Stay. The Medicare Standardized Payment Amount is the total amount that Medicare paid adjusted for geographic differences in payment rates. This applies only to the IRF Provider by CMG supplemental file.
AVG_CHRG_PER_DAY	Average Charge Per Day	Average of the Total Charge Amount per Day. The Total Charge Amount is the total charges submitted by the provider.
AVG_ALOWD_AMT_PER_DAY	Average Allowed Amount Per Day	Average of the Medicare Allowed Amount per Day. The Medicare Allowed Amount is the sum of the amount Medicare pays, the deductible and coinsurance amounts that the beneficiary is responsible for paying, and any amounts that a third party is responsible for paying. This applies only to the IRF Provider by CMG supplemental file.
AVG_PYMT_AMT_PER_DAY	Average Payment Amount Per Day	Average of the Total Medicare Payment Amount per Day. The Total Medicare Payment Amount is the total amount that Medicare paid after deductible and coinsurance amounts have been deducted.
AVG_STDZD_PYMT_AMT_PER_DAY	Average Standardized Payment Amount Per Day	Average of the Total Medicare Standardized Payment Amount per Day. The Medicare Standardized Payment Amount is the total amount that Medicare paid adjusted for geographic differences in payment rates.

Medicare Post-Acute Care Utilization - IRF Supplemental Data Dictionary

Variable Name	Term Name	Definition
CASEMIX	Casemix Grouping	Casemix Grouping associated with an IRF CMG. CMG groupings include (a) Stroke (STROK), (b) Traumatic/Non-traumatic brain spinal cord injury & major multiple trauma (INJURY_TRMA), (c) Orthopedic (ORTHO), (d) Arthritis (ARTHRTS), (e) Cardiac or Pulmonary (CRDVSCLR_PLMNRY), (f) Neurological (NRLGCL), (g) Other (OTHR). Stroke CMGs include codes beginning with "01" at any age or level of motor or cognitive impairment; the principle diagnosis in this category is stroke. Traumatic/non-traumatic brain, spinal cord injury & major multiple trauma CMGs include codes beginning with "02", "03", "04", "05", "17", or "18" at any level of motor or cognitive impairment; the principal diagnoses in this category includes traumatic brain injury, non-traumatic brain injury, traumatic spinal cord injury, non-traumatic spinal cord injury, major multiple trauma without brain or spinal cord injury, and major multiple trauma with brain or spinal cord injury. Orthopedic CMGs include codes beginning with "07", "08", or "09" at any age or level of motor impairment; the principle diagnoses in this category are fracture of lower extremity, replacement of lower extremity joint, or other orthopedic diagnosis. Arthritis CMGs include codes beginning with "12" or "13" at any level of motor impairment; the principle diagnoses in this category include osteoarthritis, rheumatoid arthritis, or other arthritis. Cardiac or pulmonary CMGs include codes beginning with "14" or "15" at any level of motor impairment; the principal diagnoses in this category include cardiac and pulmonary diagnoses. Neurological CMGs include codes beginning with "06" at any
CASEMIX_DAY_PCT	Percent (%) of Days of Service for Casemix Grouping	Percent of TOT_SRVC_DAYS associated with respective IRF Casemix Grouping.