EXPANDED MODIFIED MEDPAR FILE

UPDATED MARCH 2009

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EXPANDED MODIFIED MEDPAR FILE

The Medicare Provider Analysis and Review (MEDPAR) file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services. The records are stripped of most data elements that will permit identification of beneficiaries. The hospital is identified by the six-position Medicare bill number. The file is available to persons qualifying under the terms of the routine use act as outlined in the December 24, 1984, Federal Register, and amended by the July 2, 1985 notice.

SIGNED DATA RELEASE AGREEMENT REQUIRED. FOR ALL FILES REQUIRING A SIGNED DATA RELEASE AGREEMENT, PLEASE WRITE OR CALL TO OBTAIN A BLANK AGREEMENT FORM BEFORE PLACING ORDER.

Two versions of this file are created each year.

l. Notice of Proposed Ruling (NPRM) published in the Federal Register, usually available by the end of May. This file is derived from the MEDPAR file with a cutoff of three months after the end of the fiscal year (December file).

2. Final Rule published in the Federal Register, usually available by the first week of September. This file is derived from the MEDPAR file with a cutoff of six months after the end of the fiscal year (March file).

The file specifications for the Expanded Modified MEDPAR File are as follows:

Record Length	-	562
Blocksize	-	27538
Record Format	-	Fixed
Sort Sequence	-	Medicare Provider Number (Field 13)
Layout Changes	-	**Addition of DRG Version 24**
		Addition of Present on Admission Indicator

EXPANDED MODIFIED MEDPAR

RECORD FORMAT

EXPANDED MODIFIED MEDPAR FILE

FIELD NUMBER	DATA ELEMENT NAME	LOCATION	COBOL PICTURE
1	Filler	1	X(01)
2	Age	2	X(01)
3	Sex	3	X(01)
4	Race	4	X(01)
5	Medicare Status Code (MSC)	5-6	X(02)
6	State	7-8	X(02)
7	Filler	9-11	X(03)
8	Filler	12	X(01)
9	Filler	13	X(01)
10	Day of Admission	14	9(01)
11	Discharge Status	15	X(01)
12	HMO Paid Indicator	16	X(01)
13	PPS Indicator	17	X(01)
14	MEDPAR Provider Number	18-23	X(06)
15	Special Unit Character Code	24	X(01)
16	Stay Indicator	25	X(01)
17	Number of Bills	26-28	9(03)
18	DRG Version 24	29-31	X(03)
19	Filler	32	X(01)
20	Admission Date	33-35	9(03)
21	Discharge Date	36-38	9(03)
22	Filler	39	X(01)
23	Filler	40	X(01)
24	Filler	41	X(01)
25	Filler	42	X(01)
26	Length of Stay	43-47	9(05)
27	Outlier Days	48-50	9(03)
28	Covered Days	51-55	9(05)
29	Coinsurance Days	56-58	9(03)
30	Lifetime Reserve Days	59-61	9(03)
31	Filler	62	X(01)
32	Filler	63	X(01)
33	Filler	64	X(01)

34	Coinsurance Amount	65-71	9(07)
35	Inpatient Deductible	72-78	9(07)
36	Blood Deductible	79-85	9(07)
37	Primary Payer Amount	86-92	9(07)
38	Outlier Amount	93-99	9(07)
39	Disproportionate Share Amt	100-106	9(07)
40	Indirect Med Education Amt	107-113	9(07)
41	DRG Price	114-120	9(07)
42	Bill Total Per Diem	121-127	9(07)
43	PPS Capital Total Amount	128-134	9(07)
44	Filler	135	X(01)
45	Filler	136	X(01)
46	Filler	137-143	X(07)

FIELD NUMBER	DATA ELEMENT NAME	LOCATION	COBOL PICTURE
47	Total Charges	144-150	9(07)
48	Covered Charges	151-157	9(07)
49	Reimbursement Amount	158-164	9(07)
50	Total Accommodations Charges	165-171	9(07)
51	Total Departmental Charges	172-178	9(07)
52	Accommodation Days	179-193	9(03)
	Occurs 5 times		
53	Accommodation Charges	194-228	9(07)
	Occurs 5 times		
54	Service Charges	229-403	9(07)
	Occurs 25 times		
55	Intensive Care Indicator	404	X(01)
56	Coronary Care Indicator	405	X(01)
57	Pharmacy Indicator	406	9(01)
58	Transplant Indicator	407	9(01)
59	Radiology Indicator	408-413	9(01)
	Occurs 6 times		
60	Outpatient Services Indicator	414	9(01)
61	Organ Indicator	415-416	X(02)
62	ESRD Setting Indicator	417-426	X(02)
	Occurs 5 times		
63	Number of Diagnosis Codes	427-428	9(02)
64	Diagnostic Codes	429-473	X(05)
	Occurs 9 times		
65	Surgery Indicator	474	X(01)
66	Number of Surgical Codes	475-476	9(02)
67	Filler	477	X(01)
68	Surgical Codes	478-501	X(04)
	Occurs 6 times		
69	Filler	502	X(01)
70	Blood Furnished	503-505	9(03)
71	Filler	506	X(01)
72	DRG Version 25	507-509	9(03)
73	Discharge Destination	510-511	9(02)
74	Outlier Code/DRG Source	512	9(01)

75	Primary Payer Code	513	X(01)
76	MEDPAR ESRD Condition	514-515	9(02)
77	Source of Admission	516	X(01)
78	Type of Admission	517	X(01)
79	Intermediary Number	518-522	X(05)
80	Admission Diagnosis Code	523-527	X(05)
81	Filler	528	X(01)
82	Filler	529	X(01)
83	Admission To Death Interval	530-534	9(05)
84	DRG Version 26	535-537	9(03)
85	DRG Version 27	538-540	9(03)
86	POA Indicator	541-550	X(10)
87	Filler	551-552	X(2)
88	National Provider ID	553-562	X(10)

EXPANDED MODIFIED MEDPAR

RECORD DATA DESCRIPTIONS

01 FILLER

(FOR FUTURE USE)

02 AGE

Description:

The beneficiary's age is computed as of day of admission. It is calculated from the Julian date of birth.

Coding Scheme:

Age is a one-position field with the following code:

1 = less than 25
2 = 25 - 44
3 = 45 - 64
4 = 65 - 69
5 = 70 - 74
6 = 75 - 79
7 = 80 - 84
8 = 85 - 89
9 = 90 and over

Original Source:

SSA and RRB Beneficiary Record Systems

03 SEX

Description:

This field specifies the sex of the beneficiary.

Coding Scheme:

0 - Unknown*
1 - Male
2 - Female

Original Source:

SSA and RRB Beneficiary Record Systems

Limitations:

* Unknown is usually an RRB deficiency in reporting. If the sex is not indicated on the bill, code the sex as unknown.

04 RACE

Description:

This field specifies the beneficiary's race.

Coding Scheme:

0 - Unknown
1 - White
2 - Black
3 - Other
4 - Asian
5 - Hispanic
6 - North America Native

Original Source:

SSA and RRB Beneficiary Record Systems

Limitations:

Unknown

05 MEDICARE STATUS CODE (MSC)

Description:

This field specifies the reason for Medicare entitlement as of a point in time.

Coding Scheme:

10 - Aged without End Stage Renal Disease (ESRD)
11 - Aged with ESRD
20 - Disabled without ESRD
21 - Disabled with ESRD
31 - ESRD only

Original Source:

This field is coded from age, original reason for entitlement, current reason for entitlement and ESRD indicator (See Attachment A) contained in the master enrollment (HIMaster) file at the Central Office at the date of processing.

Limitations:

Unknown

06 STATE

Description:

State is a two-position field which specifies the s tate of residence of the beneficiary and is based on the mailing address used for cash benefits or the mailing address used for other purposes (for example, premium billing). This information is maintained from change of address notices sent in by the beneficiaries, and is appended to the record at time of processing in central office. The coding system is the SSA system, not the Federal Information Processing Standard (FIPS).

Coding Scheme:

01	- Alabama
53	- Wyoming
54-62	- Foreign Countries
63-64	- US Possessions and American SAMOA
65-66	- Pacific Territories
94-96	- Army Post Offices
97-99	- Pacific Territories

Codes 01 - 53 arrange the 50 states, D.C., Puerto Rico, and the Virgin Islands alphabetically. See Attachment C for list of state codes.

Original Source:

SSA and RRB Beneficiary Record Systems. For RRB beneficiaries, the state is coded in SSA based on mailing address.

Limitations:

Invalid or unknown states are coded "99."

In some cases, the code may not be the actual state of residence (for example, if the beneficiary has a representative payee).

The last three positions in this field contain blanks.

07 FILLER

(FOR FUTURE USE)

08 FILLER

(FOR FUTURE USE)

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09          FILLER


                    (FOR FUTURE USE)
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10 DAY OF ADMISSION

Description:

This one-position field specifies the day of the week the admission occurred.

Coding Scheme:

1 - Sunday
2 - Monday
3 - Tuesday
4 - Wednesday
5 - Thursday
6 - Friday
7 - Saturday

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

11 DISCHARGE STATUS

Description:

This field specifies the beneficiary's condition on the date of discharge from the hospital.

Coding Scheme:

A - Discharged alive
B - Discharged dead
C - Still a patient

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

12 HMO/PAID INDICATOR

Description:

This field specifies (a) whether an HMO is paying for services provided, (b) whether the patient has been readmitted within seven days of an earlier discharge, or (c) both. This field may contain blanks.

Coding Scheme:

0 - Not paid by HMO
1 - Paid by HMO

Original Source:

Coded at the Central Office

Limitations:

Unknown

13 PPS Indicator

Description:

This field specifies whether a hospital is being paid under the Prospective Payment System (PPS).

Coding Scheme:

Code 0 = Not PPS
1 = PPS

Original Source:

The PPS Indicator is set at the Central Office and is coded by the intermediary. A code other than "65" in the Unibill Condition Code field indicates that this is a PPS provider.

Limitations:

Experience with the indicator shows that it was unreliable in l983, l984, and l985.

14 MEDICARE PROVIDER NUMBER

Description:

This field specifies the institution that rendered services to a beneficiary. This is the unique number issued by the HCFA Regional Office to a provider of services upon initial certification for participation in the Medicare program. For a more detailed description of the provider number, see Attachment B.

Coding Scheme:

SSTPPP where:

- SS = State of the provider (SSA standard State Codes) - See Attachment C.
- T = Type of provider
- PPP = Provider sequence number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

The MEDPAR File contains only inpatient hospital records. Provider numbers are validated against a file of Medicare-certified providers by the intermediary. However, this process is not repeated when the MEDPAR file is constructed.

15 SPECIAL UNIT CHARACTER CODE

Description:

This field specifies the PPS-exempt special care units of inpatient hospitals.

Coding Scheme:

S - Psychiatric unit (PPS-exempt)
T - Rehabilitation unit (PPS-exempt)
U - Short term/acute care swing-bed hospital
W - Long term hospital swing-bed
Y - Rehab hospital swing-bed
Z - Swing-bed rural primary care hospital;
eff. 10/97 changed to critical access hospitals
Blank - Not a PPS-exempt unit or swing-bed designation

Original Source:

This is a unique identifier issued by the HCFA Regional Office to a provider of service. The non-blank code replaces the third digit of the provider number on incoming bills.

Limitations:

Effective with provider cost reporting periods beginning on or after October 1, l987, the Alcohol/Drug units are no longer PPS-exempt units.

16 STAY INDICATOR

Description:

This field specifies the type of stay.

Coding Scheme:

S - Short stay
L - Long stay
N - SNF

Original Source:

Derived from Uniform Bill, Form HCFA-1450

Limitations:

Unknown

17 NUMBER OF BILLS

Description:

This field specifies the number of bills for a stay.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Generated from the stay record at Central Office

Limitations:

Unknown

18 DRG Version 24

Description:

Each DRG represents broad clinical categories that are based on body system involvement and disease etiology. Each category is similar in its use of diagnostic resources and is identified using specific guidelines. Each category must have been clinically consistent, had a sufficient number of patients, and covered the complete range of diagnoses represented in the ICD-9-CM, without overlap. The categories were developed by a Yale University research team and revised by Health Services International, Inc.

* Please note: For the purposes of IPPS regulation development, the Present on Admission (POA) indicator was not considered in the grouping process. The groupings in this file reflect the DRG into which the case is categorized without incorporating any POA indicators.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Added to the record by the intermediary's GROUPER software, which translates variables such as age, sex, diagnosis and surgical codes into the single applicable DRG.

Limitations:

DRG 469 and DRG 470 are categories that could not be accurately classified into valid DRGs.

19 FILLER

(FOR FUTURE USE)

20 ADMISSION DATE

Description:

This field specifies the date of the beneficiary's admission to the institution translated into the quarter of the year in which the admission occurred.

Coding Scheme:

QYY where:

- 1YY = First quarter of year
- 2YY = Second quarter of year
- 3YY = Third quarter of year
- 4YY = Fourth quarter of year

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

21 DISCHARGE DATE

Description:

This field specifies the date on which the beneficiary was discharged translated into the quarter of the year in which the discharge occurred.

Coding Scheme:

QYY where:

- 1YY = First quarter of year
- 2YY = Second quarter of year
- 3YY = Third quarter of year
- 4YY = Fourth quarter of year

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

22 FILLER

(FOR FUTURE USE)

23 FILLER

(FOR FUTURE USE)

24 FILLER

(FOR FUTURE USE)

25 FILLER

(FOR FUTURE USE)

26 LENGTH OF STAY

Description:

This field specifies the total length of a patient's hospital stay from the date of admission to the date of discharge.

Coding Scheme:

Length of stay is obtained by subtracting the date of admission from the date of discharge. If the difference was 0, it was made 1.

Original Source:

Uniform Bill, Form HCFA-1450

27 OUTLIER DAYS

This field specifies the number of days paid as outliers under PPS and the days over the threshold for the DRG. The number can be a day or cost outlier.

Coding Scheme:

Three-position field nnn, where n is a number.

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

28 COVERED DAYS

Description:

This field specifies the number of days of care (including coinsurance and lifetime reserve days) covered by Medicare which the beneficiary used during this stay as an inpatient.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

29 COINSURANCE DAYS

Description:

This field specifies the actual number of coinsurance days that the beneficiary used during this hospital stay. The coinsurance days are the 61st through the 90th day of the spell of illness, plus the lifetime reserve days used.

Coding Scheme:

Three-position field nnn, where n is a number.

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

30 LIFETIME RESERVE DAYS

Description:

This field specifies the number of lifetime reserve days used by a beneficiary during this stay. Each beneficiary has a lifetime reserve of 60 additional days of Medicare coverage for inpatient hospital services beginning with the 91st day of care in a spell of illness.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

31 FILLER

(FOR FUTURE USE)

32 FILLER

(FOR FUTURE USE)

33 FILLER

(FOR FUTURE USE)

34 COINSURANCE AMOUNT

Description:

This field specifies the amount shown, which is the number of coinsurance days multiplied by the applicable coinsurance rate paid by the patient.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

35 INPATIENT DEDUCTIBLE

Description:

This field specifies the amount identified by the hospital as the patient's liability for inpatient deductible.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

36 BLOOD DEDUCTIBLE

Description:

This field specifies the amount identified by the hospital as the patient's liability for blood used.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

37 PRIMARY PAYER AMOUNT

Description:

This field specifies the amount paid by the primary insurer for the beneficiary's stay in the hospital.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

38 OUTLIER AMOUNT

Description:

This field specifies the amount paid over the DRG allowance. This amount is included in the Reimbursement Amount.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown

39 DISPROPORTIONATE SHARE

Description:

This field specifies the amount paid over the DRG for the disproportionate share hospital. This amount is included in the Reimbursement Amount.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown

40 MEDPAR IME Amount

Description:

This field specifies the additional amount paid to teaching hospitals for IME. This amount is included in the Reimbursement Amount.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown

41 DRG PRICE

Description:

This field specifies the DRG price, which is the sum of the Reimbursement, Primary Payer Amount, Coinsurance Amount, Inpatient Deductible, and Blood Deductible non-covered charges, less the Outlier Amount ((R + P + C + I + B) - O = DRG Price).

Coding Scheme:

Charges are rounded to whole dollars

Original source:

Computed by the Fiscal Intermediary for all discharges

Limitations:

Unknown

42 BILL TOTAL PER DIEM

Description:

This field specifies the total per diem amount derived by multiplying the per diem from the bill by the number of covered days. This field includes payments for Graduate Medical Education (GME), Direct Medical Education (DME), and bad debts.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

43 CAPITAL TOTAL AMOUNT

Description:

This field specifies the total reimbursement for depreciation, rent, certain interest, and real estate taxes for hospital buildings and equipment subject to the PPS, effective with hospital cost reporting periods on or after October, 1991. This amount is included in the Reimbursement Amount.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown

44 FILLER

(FOR FUTURE USE)

45 FILLER

(FOR FUTURE USE)

46 FILLER

(FOR FUTURE USE)

47 TOTAL CHARGES

Description:

This field specifies the total charges, including non-covered charges, for the beneficiary reported for this hospital stay.

Coding Scheme:

Total is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450, reported in (Total Charges) and identified by (Revenue Code 001)

Limitations:

An anomaly has been discovered when discharges contain zeros in the Total Charges field. At this time, the cause is unknown. Since these records represent 0.002 percent of the file, users are asked to delete them as errors.

48 COVERED CHARGES

Description:

This field specifies the portion of total charges covered by Medicare.

Coding Scheme:

Proportional amount is rounded to whole dollars

Original Source:

This field is derived at the Central Office by subtracting non-covered charges from total charges.

Limitations:

Unknown

49 REIMBURSEMENT AMOUNT

Description:

This field specifies the amount paid to the provider and/or patient by Medicare for the services reported on the bill. This amount includes Outlier, Disproportionate Share, Indirect Medical Education (IME), and Capital Total amounts, but does not include Bill Total Per Diem. In addition, it excludes amounts paid by or on behalf of the patient.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

IME was excluded before October, 1989. This field may be zero if Medicare is not the primary payer.

50 TOTAL ACCOMMODATIONS CHARGES

Description

This field specifies the whole dollar amount of the total charges fields for all accommodations (private room, semi-private room, ward, intensive care and coronary care units) reported for the beneficiary during this hospital stay.

Coding Scheme:

Total is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450, summation of (Total Charges) and identified by (Revenue Codes 10X through 18X)

Limitations:

Unknown

51 TOTAL DEPARTMENTAL CHARGES

Description:

This field specifies the total of the separate departmental charges for the beneficiary reported during this hospital stay.

Coding Scheme:

Total is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450, reported in (Total Charges) and identified by (Revenue Codes 22X through 99X)

Limitations:

Unknown

52 ACCOMMODATION DAYS

Description:

This field specifies the number of days for all routine accommodations.

Coding Scheme:

Occur five times (See Attachment D for explanation of each occurrence.)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

53 ACCOMMODATION CHARGES

Description:

This field specifies the number of charges for all routine accommodations.

Coding Scheme:

Occur five times (See Attachment E for explanation of each occurrence.)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

54 SERVICE CHARGES

Description:

This field specifies the number of charges for various services, e.g., used durable equipment, pharmacy, radiology.

Coding Scheme:

Occur 25 times (See Attachment F for explanation of each occurrence.)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

55 INTENSIVE CARE INDICATOR

Description:

This field specifies that the beneficiary has spent time under intensive care and indicates the type of ICU.

Coding Scheme:

0 - General (Revenue Center 0200)
1 - Surgical (Revenue Center 0201)
2 - Medical (Revenue Center 0202)
3 - Pediatric (Revenue Center 0203)
4 - Psychiatric (Revenue Center 0204)
6 - Intermediate IOU; (Revenue Center 0206) prior to 12/96 update was 'post ICU'
7 - Burn care (Revenue Center 0207)
8 - Trauma (Revenue Center 0208)
9 - Other intensive care (Revenue Code 0209)
Blank - No intensive care indication

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

56 CORONARY CARE INDICATOR

Description:

This field specifies that the beneficiary has spent time under coronary care and indicates the type of coronary care unit.

Coding Scheme:

0 - General (Revenue Code 0210)
1 - Myocardial infarction (Revenue Code 0211)
2 - Pulmonary care (Revenue Code 0212)
3 - Heart transplant (Revenue Code 0213)
4 - Intermediate CCU (Revenue Code 0214) prior to 12/96 update was 'post ICU'
9 - Other coronary care (Revenue Code 0219)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

57 PHARMACY INDICATOR

Description:

This field specifies that the beneficiary has received drugs during a stay.

Coding Scheme:

0 - No drugs (Revenue Code other than those listed below)
1 - General drugs and/or IV therapy (Revenue Code 025X, 026X)
2 - Erythropoietin (Revenue Code 0630, 0635, 0637, 0639)
3 - Blood clotting drugs Revenue Code 0636)
4 - General drugs and/or IV therapy, Erythropoietin (Combination of values 1 and 2)
5 - General drugs and/or IV therapy, and blood clotting drugs (Combination of values 1 and 3)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

58 TRANSPLANT INDICATOR

Description:

This field specifies whether the beneficiary has had a transplant.

Coding Scheme:

0 - No organ or kidney transplant(Revenue Code not 0362 or 0367)
2 - Organ transplant other than kidney (Revenue Code 0362)
7 - Kidney transplant (Revenue Code 0367)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

59 RADIOLOGY INDICATORS

Description:

This field specifies the type of radiologic treatment a beneficiary has received.

Coding Scheme:

Occurs six times

Codes are positional. Whenever 1 appears in the string of six (6) zeroes, the code will specify a particular radiology treatment.

1st position - Radiology-Oncology (Revenue Code 028X)
2nd position - Radiology-diagnostic (Revenue Code 032X)
3rd position - Radiology-therapeutic (Revenue Code 033X)
4th position - Radiology-Nuclear medicine (Revenue Code 034X)
5th position - Radiology CT scan (Revenue Code 035X)
6th position - Radiology Other imaging services (Revenue Code 040X)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

60 OUTPATIENT SERVICES INDICATOR

Description:

This field specifies whether the beneficiary has received outpatient services, ambulatory surgical care, or both.

Coding Scheme:

0 - No outpatient services/Ambulatory Surgical Care)
(Revenue Code other than 049X, 050X)
1 - Outpatient services (Revenue Code 050X)
2 - Ambulatory surgical care (Revenue Code 049X)
3 - Outpatient services and ambulatory surgical care
(Revenue Codes 049X and 050X)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

61 ORGAN INDICATOR

Description:

This field specifies the type of organ transplant.

Coding Scheme:

K1 - General classification (Revenue Code 0810)
K2 - Living donor kidney (Revenue Code 0811)
K3 - Cadaver donor kidney (Revenue Code 0812)
K4 - Unknown donor kidney (Revenue Code 0813)
K5 - Other kidney acquisition (Revenue Code 0814)
H1 - Cadaver donor heart (Revenue Code 0815)
H2 - Other heart acquisition (Revenue Code 0816)
L1 - Donor liver (Revenue Code 0817)
01 - Other organ acquisition (Revenue Code 0819)
02 - General classification Revenue Code 0890)
B1 - Bone donor bank (Revenue Code 0891)
03 - Organ donor bank other than kidney (Revenue code 0892)
S1 - Skin donor bank (Revenue Code 0893)
04 - Other donor bank (Revenue Code 0899)
Blank - no organ acquisition indication

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

62 ESRD SETTING

Description:

This field specifies the type of dialysis used on the beneficiary.

Coding Scheme:

Inpatient Renal Dialysis
- 00 - General (Revenue Code 0800)
- 01 - Hemodialysis (Revenue Code 0801)
- 02 - Peritoneal (non-CAPD: Revenue code 0802)
- 03 - CAPD (Revenue Code 0803)
- 04 - CCPD (Revenue Code 0804)
- 09 - Other (Revenue Code 0809)

Hemodialysis-Outpatient
- 20 - General (Revenue Code 0820)
- 21 - Hemodialysis/composite (Revenue Code 0821)
- 22 - Home supplies (Revenue Code 0822)
- 23 - Home equipment (Revenue Code 0823)
- 24 - Maintenance/100% (Revenue Code 0824)
- 25 - Support services (Revenue Code 0825)
- 29 - Other (Revenue Code 0829)

Peritoneal Dialysis-Outpatient/Home
- 30 - General (Revenue Code 0830)
- 31 - Peritoneal/composite (Revenue Code 0831)
- 32 - Home supplies (Revenue Code 0832)
- 33 - Home equipment (Revenue Code 0833)
- 34 - Maintenance/100% (Revenue Code 0834)
- 35 - Support services (Revenue Code 0835)
- 39 - Other (Revenue Code 0839)

CAPD Outpatient
- 40 - CAPD General (Revenue Code 0840)
- 41 - CAPD/composite (Revenue Code 0841)
- 42 - Home supplies (Revenue Code 0842)
- 43 - Home equipment (Revenue Code 0843)
- 44 - Maintenance/100% (Revenue Code 0844)
- 45 - Support services (Revenue Code 0845)
- 49 - Other (Revenue Code 0849)

62 ESRD SETTING (continued)

CCPD Outpatient
- 50 - CCPD General (Revenue Code 0850)
- 51 - CCPD/composite (Revenue Code 0851)
- 52 - Home supplies (Revenue Code 0852)
- 53 - Home equipment (Revenue Code 0853)
- 54 - Maintenance/100% (Revenue Code 0854)
- 55 - Support services (Revenue Code 0855)
- 59 - Other (Revenue Code 0859)

Miscellaneous Dialysis
- 80 - General (Revenue Code 0880)
- 81 - Ultrafiltration (Revenue Code 0881)
- 89 - Other (Revenue Code 0889)
- Blank - No ESRD setting indication

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

63 NUMBER OF Diagnosis CODES

Description:

This field specifies the number of diagnosis codes present in the stay record (i.e., the number of fields that are not blank).

Coding Scheme:

Two-position field nn, where n is a number (1-10)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations

Unknown

64 DIAGNOSIS CODE

Description:

This field specifies the principal and other diagnosis codes that are obtained from the patient's discharge bill. Principal diagnosis is defined as the condition established, after study, that is chiefly responsible for admission of the patient. The principal diagnosis is reported first, followed by up to eight additional diagnoses. The order of these eight is at the discretion of the provider.

Coding Scheme:

Coding is based on International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM). Providers key the ICD-9-CM code from the bills and report the information to HCFA as part of the claims tape record. Each code can be up to five characters, left justified.

Original Source:

Uniform Bill, Form HCFA-1450

Limitations

May contain invalid codes

65 SURGERY INDICATOR

Description:

This field specifies whether or not there were any surgical procedures performed during the beneficiary's stay.

Coding Scheme:

0 - No surgery indicated
1 - Yes surgery indicated

Original Source:

This field is derived at the Central Office.

Limitations:

Unknown

66 NUMBER OF SURGICAL CODES

Description:

This field specifies the number of surgical codes reported.

Coding Scheme:

Two-position field nn, where n is a number (0-6)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

67 FILLER

(FOR FUTURE USE)

68 SURGICAL CODE

Description:

This field specifies the ICD-9-CM codes that correspond to the surgical procedures performed during the beneficiary's stay.

Coding Scheme:

Occur 6 times

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

69 FILLER

(FOR FUTURE USE)

70 BLOOD FURNISHED

Description:

This field specifies the total number of pints of whole blood or units of packed red cells furnished, regardless of whether they were replaced. Blood is reported in complete units rounded upwards. This entry serves as the basis for counting pints toward the blood deductible and must, therefore, include both replaced and unreplaced blood.

Coding Scheme:

Three-position field nn, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Based on an analysis of aggregated records, there appears to be a misinterpretation by some providers of the format (i.e., the field is to contain whole units, but it appears, in some cases, to be reported with tenths of units).

71 FILLER

(FOR FUTURE USE)

72 DRG Version 25

Description:

Each DRG represents broad clinical categories that are based on body system involvement and disease etiology. Each category is similar in its use of diagnostic resources and is identified using specific guidelines. Each category must have been clinically consistent, had a sufficient number of patients, and covered the complete range of diagnoses represented in the ICD-9-CM, without overlap. The categories were developed by a Yale University research team and revised by Health Services International, Inc.

* Please note: For the purposes of IPPS regulation development, the Present on Admission (POA) indicator was not considered in the grouping process. The groupings in this file reflect the DRG into which the case is categorized without incorporating any POA indicators.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Added to the record by the intermediary's GROUPER software, which translates variables such as age, sex, diagnosis and surgical codes into the single applicable DRG.

Limitations:

DRG 998 and DRG 999 are categories that could not be accurately classified into valid DRGs.

73 DISCHARGE DESTINATION

Description:

This field specifies the destination of the patient after discharge from the hospital.

Coding Scheme:

01 - Discharged to home/self care (routine charge).
02 - Discharged/transferred to other short term general hospital for inpatient care.
03 - Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing-bed arrangement, use Code 61 - swing-bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
04 - Discharged/transferred to intermediate care facility (ICF).
05 - Discharged/transferred to another type of institution for inpatient care (including distinct parts).
06 - Discharged/transferred to home care of organized home health service organization.
07 - Left against medical advice or discontinued care.
08 - Discharged/transferred to home under care of a home IV drug therapy provider.
09 - Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20 - Expired (did not recover -(Christian Science patient).
30 - Still patient.
40 - Expired at home (hospice claims only).

41 - Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
42 - Expired - place unknown (Hospice claims only)
43 - Discharged/transferred to a federal hospital (eff. 10/1/03)
50 - Hospice - home (eff. 10/96)
51 - Hospice - medical facility (eff. 10/96)
61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
62 - Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
63 - Discharged/transferred to a long term care hospital. (eff. 1/2002)
64 - Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.(eff. 10/2002)
65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital.(eff. 1/2005)
66 - Discharged/transferred to a Critical Access Hospital (CAH). (eff. 1/1/06)
71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care. (eff. 9/2001)
72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care.(eff. 9/2001)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

74 OUTLIER CODE/DRG SOURCE

Description:

This field specifies two mutually exclusive conditions. The first, for PPS providers (codes 0, 1, and 2), if the stay has an unusually long length (day outlier) or high cost (cost outlier) or the second, for non-PPS providers (codes 6, 7, 8, and 9), denotes the source for developing the DRG.

Coding Scheme:

One-position field showing the Outlier Code/DRG Source.

Codes applicable to PPS Providers:

0 - No outlier
1 - Day outlier
2 - Cost outlier

Codes applicable to non-PPS Providers:

6 - Valid DRG received from the Intermediary
7 - HCFA-developed DRG
8 - HCFA-developed DRG using claim status code
9 - Not groupable

Original Source:

This field is coded at the Central Office.

Limitations:

Unknown

75 PRIMARY PAYER CODE

Description:

This field specifies the payer of this claim.

Coding Scheme:

A - Working aged beneficiary/spouse with Employer Group Health Plan (EGHP)
B - ESRD beneficiary in eighteen-month coordination period with EGHP
C - Conditional medicare payment; future reimbursement expected
D - Automobile no-fault or any liability insurance
E - Worker's compensation
F - PHS or other Federal agency (other than Dept. of Veterans Affairs)
G - Working disabled
H - Black Lung
I - Depart of Veterans Affairs
J - Any liability insurance
Z/Blank - Medicare is primary payer

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

76 MEDPAR ESRD CONDITION CODE

Description

This field specifies the ESRD condition codes found on the beneficiary's bill. (medpar_ESRD_cond_c)

Coding Scheme:

00 - No ESRD
70 - Self-administered EPO
71 - Full care in unit
72 - Self-care in unit
73 - Self-care training
74 - Home dialysis
75 - Home dialysis/100% reimbursement
76 - Backup-in-facility dialysis

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

77 SOURCE OF ADMISSION

Description:

This field specifies the type of admission for inpatient hospital stays.

Coding Scheme:

0 - ANOMALY: invalid value, if present, translate to '9'
1 - Physician referral - The patient was admitted upon the recommendation of personal physician.
2 - Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
3 - HMO referral - The patient was admitted upon the recommendation of a Health Maintenance Organization (HMO) physician.
4 - Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility.
5 - Transfer from a Skilled Nursing Facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.

6 - Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.
7 - Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.
8 - Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
9 - Information not available - The means by which

the patient was admitted is not known.

A - Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

B - Transfer from another Home Health Agency - The patient was admitted to this home health agency as a transfer from another home health agency.

C - Readmission to Same Home Health Agency - The patient was readmitted to this home health agency within the same home health episode period.

D - Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

For Newborn Type of Admission

.

1 - Normal delivery - A baby delivered without complications.

2 - Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status.

3 - Sick baby - A baby delivered with medical complications, other than those relating to premature status.

4 - Extramural birth - A baby delivered in a nonsterile environment.

5-8 Reserved for national assignment.

9 - Information not available.

Original Source:

Uniform Bill, Form HCFA-1450

Limitations: Unknown

78 TYPE OF ADMISSION

Description:

This field specifies the basic types of admission for inpatient hospital stays.

Coding Scheme:

1 The code indicating the type and priority of an inpatient admission associated with the service on an intermediary submitted claim.

STANDARD ALIAS: CLM_IP_ADMSN_TYPE_CD
SQL ALIAS: IP_ADMSN_TYPE_CD
SAS ALIAS: TYPE_ADM
TITLE ALIAS: IP_ADMISSION_TYPE

CODES:
0 - Blank
1 - Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2 - Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
3 - Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations.
4 - Newborn - Necessitates the use of special source of admission codes.
5-8 Reserved.
9 - Unknown - Information not available.

Original Source:

Xeroxed from NCH

Limitations:

Unknown

79 INTERMEDIARY NUMBER

Description:

This field specifies the identifying number of the intermediary processing the bill.

Coding Scheme:

For the first two positions:
00 - Blue Cross
nn - Commercial Plan

00010 - Alabama BC - Alabama
00011 - Alabama BC - Iowa
00020 - Arkansas BC
00030 - Arizona BC
00040 - California BC (term. 12/00)
00050 - New Mexico BC/CO (term. 06/89)
00060 - Connecticut BC (term. 06/99)
00070 - Delaware BC -(term.02/98)
00080 - Florida BC -(term. 03/88)
00090 - Florida BC
00101 - Georgia BC
00121 - Illinois - HCSC (term. 08/98)
00123 - Michigan - HCSC (term. 08/98)
00130 - Indiana BC/Administar Federal
00131 - Illinois - Administar
00140 - Iowa - Wellmark (term. 6/2000)
00150 - Kansas BC
00160 - Kentucky/Administar
00180 - Maine BC
00181 - Maine BC - Massachusetts
00190 - Maryland BC
00200 - Massachusetts BC (term. 07/97)
00210 - Michigan BC (term. 09/94)
00220 - Minnesota BC (term. 07/99)
00230 - Mississippi BC
00231 - Mississippi BC/LA (term. 09/92)
00232 - Mississippi BC
00241 - Missouri BC (term. 09/92)
00250 - Montana BC

00260 - Nebraska BC
00270 - New Hampshire/VT BC
00280 - New Jersey BC (term. 08/00)
00290 - New Mexico BC - (term. 11/95)
00308 - New York - Empire BC
00310 - North Carolina BC (term. 01/02)
00320 - North Dakota BC
00332 - Community Mutual Ins Co; Ohio Administar
00340 - Oklahoma BC
00350 - Oregon BC
00351 - Oregon BC/ID (term. 09/88)
00355 - Oregon - CWF
00362 - Independence BC - (term. 08/97)
00363 - Pennsylvania - Veritus
00370 - Rhode Island BC
00380 - South Carolina BC
00390 - Tennessee BC
00400 - Texas BC
00410 - Utah BC (term. 09/00)
00423 - Virginia BC; Trigon (term. 08/99)
00430 - Washington/Alaska BC
00450 - Wisconsin BC - Wisconsin
00452 - Wisconsin BC - Michigan
00453 - Wisconsin BC - Virginia & West Virginia
00454 - Wisconsin BC - California
00460 - Wyoming BC
00468 - N Carolina BC/CPRTIVA
00993 - BC/BS Assoc.
17120 - Hawaii Medical Service (term. 06/99)
50333 - Travelers; Connecticut United Healthcare
(term. - date unknown)
51051 - Aetna California - (term. 06/97)
51070 - Aetna Connecticut - (term. 06/97)
51100 - Aetna Florida - (term. 06/97)
51140 - Aetna Illinois - (term. 06/97)
51390 - Aetna Pennsylvania - (term. 06/97)
52280 - NE - Mutual of Omaha
57400 - Puerto Rico - Cooperativa
61000 - Aetna (term. 06/97)
80883 - Contractor ID for Inpatient & Outpatient
Risk Adjustment Data (data not sent through
CWF; but through Palmetto)

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

80 ADMISSION DIAGNOSIS

Description:

This field specifies the ICD-9 diagnosis code at the time of admission.

Coding Scheme:

Five-position field nnnnn, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

81 FILLER

(FOR FUTURE USE)

82 FILLER

(FOR FUTURE USE)

83 ADMISSION TO Death Interval

Description:

This field specifies the number of days from the beneficiary's admission to date of death.

Coding Scheme:

Five-position field nnn, where n is a number

Original Source:

MEDPAR

Limitations:

Unknown

84 DRG Version 26

Description:

This field specifies the mapped DRG for this fiscal year. For a description of DRG, see field Diagnosis Related Group (DRG) Code.

* Please note: For the purposes of IPPS regulation development, the Present on Admission (POA) indicator was not considered in the grouping process. The groupings in this file reflect the DRG into which the case is categorized without incorporating any POA indicators.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Evaluates the billed DRG, diagnostic, and procedure codes to produce a current DRG.

Limitations:

DRG 998 and DRG 999 are categories that could not be accurately classified into valid DRGs.

85 DRG Version 27

Description:

This field projects DRG codes for the next fiscal year. For a description of DRG, see field Diagnosis Related Group (DRG) Code.

* Please note: For the purposes of IPPS regulation development, the Present on Admission (POA) indicator was not considered in the grouping process. The groupings in this file reflect the DRG into which the case is categorized without incorporating any POA indicators.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Evaluates the current DRG, diagnostic, and procedure codes to produce a proposed DRG.

Limitations:

DRG 998 and DRG 999 are categories that could not be accurately classified into valid DRGs.

86 POA Indicator

Description:

Effective September 1, 2008,
the code used to indicate a condition was
present at the time the beneficiary was admitted to
a general acute care facility.

Coding scheme:

Ten-position character field.

In the POA field, there can be up to 9 POA
indicators for each diagnosis code reflected in the
diagnosis trailer. This field will also contain a
1-byte indicator ('Z' or 'X') to identify the end
of the POA codes.

Y = Present at the time of inpatient admission
N = Not present at the time of inpatient admission
U = Documentation is insufficient to determine if
condition was present on admission
W = Provider is unable to clinically determine
whether condition was present on admission or
not.
1 = Unreported/not used -- exempt from POA reporting --
this code is the equivalent code of a blank,
however, it was determined that blanks were
undesirable when submitting the data
Z = Denotes the end of the POA indicators
X = Denotes the end of the POA indicators in special
data processing situations that may be identified
by CMS in the future.

87 FILLER

(FOR FUTURE USE)

88 National Provider ID (NPI)

Description:

Effective May 23, 2007, the National Provider Identifier (NPI) number is assigned to uniquely identify the institutional provider certified by Medicare to provide services.

Coding Scheme:

Ten-position character field.

Original Source:

Uniform Bill

Limitations:

The MEDPAR File contains only inpatient hospital records. Provider numbers are validated against a file of Medicare-certified providers by the intermediary. However, this process is not repeated when the MEDPAR file is constructed.

ATTACHMENTS

Attachment A

The Medicare Status Code (MSC) logic used by the Enrollment System follows:

Step 1 Compute Age-of-Person

Step 2 If Age > 64, enter 10 at Medicare Status Code and go to Step 4.

Step 3 Generate a Medicare Status Code using the original reason for entitlement code (OREC) and the current reason for entitlement code (CREC) and the following table:

OREC	&	CREC	=	MS CODE	OREC	&	CREC	=	MS CODE
0	&	0	=	10	1	&	0	=	20
0	&	1	=	10	1	&	1	=	20
0	&	2	=	10	1	&	2	=	20
0	&	3	=	10	1	&	3	=	20
2	&	0	=	31	3	&	0	=	20
2	&	1	=	20	3	&	1	=	20
2	&	2	=	31	3	&	2	=	20
2	&	3	=	20	3	&	3	=	20

Step 4 If Medicare Status Code = 10 or 20 AND End Stage Renal Disease Indicator (ESRDI) = A thru G, add 1 to Medicare Status Code (generate 11 or 21 codes).

Note:

Reason for Entitlement:
- 0 - OASI
- 1 - DIB
- 2 - Renal
- 3 - DIB & Renal

End Stage Renal Disease Indicator:
- 0 - No ESRD
- A - MBR
- B - HI
- C - NIH
- D - MBR & HI

Medicare Status Code:

- 10 - Aged without ESRD
- 11 - Aged with ESRD
- 20 - DIB without ESRD
- 21 - DIB with ESRD
- 31 - ESRD only

E - MBR & HI
F - HI & NIH
G - MBR, HI, & NIH
H - OAS Clerical
I - MBR/OAS Clerical
J - HI/OAS Clerical
K - NIH/OAS Clerical
L - MBR/HI/OAS Clerical
M - MBR/NIH/OAS Clerical
N - HI/NIH/OAS Clerical
P - MBR/HI/NIH/OAS Clerical

Attachment B
(Page 1)

Provider Number Coding

- The first two positions are the State code (See Attachment C).

- Position three, and sometimes position four, are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated:

0001-0879	Short-term (General and Specialty) Hospitals (where TOB = 11X; ESRD clinic where TOB = 72X)
0880-0899	Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB =72X
0900-0999	Multiple Hospital Component in a Medical Complex (Numbers Retired) where TOB =11X;ESRD clinic where TOB = 72X
1000-1199	Reserved for Future Use
1200-1224	Alcohol/Drug Hospitals (Excluded from PPS - Numbers Retired)where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical Assistance Facilities (MONTANA Project) ESRD clinic where TOB = 72X
1300-1399	Rural Primary Care Hospital (RPCH) eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499	Continuation of 4600-4799 series (CMHC)
1500-1799	Hospices
1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP P7B) where TOB = 22X; HHA where TOB = 32X, 33X, 34X eff. 7/00 changed to Religious Non Medical Health Care Institution (RNHCI)
1990-1999	Christian Science Sanatoria (Hospital Services)
2000-2299	Long-Term Hospitals (Excluded from PPS)
2300-2499	Chronic Renal Disease Facilities (Hospital Based)

2500-2899	Non-Hospital Renal Disease Treatment Centers
2900-2999	Independent Special Purpose Renal Dialysis Facility (1)
3000-3024	Formerly Tuberculosis Hospitals (Numbers Retired)
3025-3099	Rehabilitation Hospitals (Excluded from PPS)
3100-3199	Continuation 7300-7399 (HHA) (3) (eff. 4/96)
3200-3299	Continuation of 4800-4899 series (CORF)
3300-3399	Children's Hospitals (Excluded from PPS)
3400-3499	Continuation of Rural Health Clinics (provider based) (3775-3999)
3500-3699	Renal Disease Treatment Centers (Hospital Satellites)
3700-3799	Hospital Based Special Purpose Renal Dialysis Facility (1)
3800-3974	Rural Health Clinics (Free-Standing)
3975-3999	Rural Health Clinics (Provider Based)
4000-4499	Psychiatric Hospitals (Excluded from PPS)
4500-4599	Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799	Community Mental Health Centers (CMHC); 9/30/91-3/31/97 used for clinic OPT where TOB = 74*
4800-4899	Continuation of 4500-4599 series (CORF)
4900-4999	Continuation of 4600-4799 series(CMHC) 9/30/91-3/31/97 used for clinic OPT
5000-6499	Skilled Nursing Facilities CMHC/outpatient physical etc.
6500-6989	Outpatient Physical Therapy Services
6990-6999	Christian Science Sanatoria (Skilled Nursing Services) eff. 7/00 Numbers Reserved (formerly CS)
7000-7299	Home Health Agencies (HHA) (2)
7300-7399	Subunits of "Nonprofit" and "Proprietary" Home Health Agencies (3)
7400-7799	Continuation of 7000-7299 Series

Attachment B
(Page 2)

7800-7999	Subunits of State and Local Governmental Home Health Agencies (3)
8000-8499	Continuation of 7400-7799 series (HHA)
8500-8899	Continuation of Rural Health Center (provider based) (3400-3499)
8900-8999	Continuation of Rural Health Center (free standing)(3800-3974)
9000-9499	Continuation of 8000-8499 series (HHA)
9500-9999	(eff. 8/1/98) NOTE: 10/95-7/98 This series was assigned to HHA's but rescinded-no HHA's were ever assigned a number from this series.
P001-P999	Organ Procurement Organization

(1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.

(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43), and Texas (45) have been used in Reducing Acute Care Costs (RACC) Experiments.

(3) In Virginia (49), the series 7100-7299 has been reserved for Statewide Subunit Components of the Virginia State Home Health Agencies.

(4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

Exception:
P001-P999 Organ procurement organization

(1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.
(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45) have been used in reducing acute care costs (RACC) experiments.
(3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.
(4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

Note:
There is a special numbering system for units of hospitals that are excluded from Prospective Payment System (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

S = Psychiatric unit (excluded from PPS)
T = Rehabilitation unit (excluded from PPS)
U = Short term/acute care swing-bed hospital
V = Alcohol drug unit (prior to 10/87 only)
W = Long term SNF swing-bed hospital (eff 3/91)
Y = Rehab hospital swing-bed (eff 9/92)
Z = Swing Bed Designation for Critical Access Hospitals

There is also a special numbering system for assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

E = Non-federal emergency hospital
F = Federal emergency hospital

SOURCE:
UNIFORM BILL 82, FORM HCFA-1450,
ITEM 7 (MEDICARE PROVIDER NUMBER).

LIMITATIONS:
THE MEDPAR FILE CONTAINS ONLY INPATIENT HOSPITAL RECORDS. PROVIDER NUMBERS ARE VALIDATED AGAINST A FILE OF MEDICARE-CERTIFIED PROVIDERS BY THE

INTERMEDIARY. HOWEVER, THIS PROCESS IS NOT REPEATED WHEN THE MEDPAR FILE IS CONSTRUCTED.

Attachment C

STATE CODES

01	Alabama
02	Alaska
03	Arizona
04	Arkansas
05,55,75	California
06	Colorado
07	Connecticut
08	Delaware
09	District of Columbia
10,68,69	Florida
11	Georgia
12	Hawaii
13	Idaho
14,78	Illinois
15	Indiana
16,76	Iowa
17,70	Kansas
18	Kentucky
19,71	Louisiana
20	Maine
21,80	Maryland
47	Vermont
48	Virgin Islands
49	Virginia
50	Washington
51	West Virginia
52	Wisconsin
53	Wyoming
54	Africa
56	Canada
57	Central America and West Indies
58	Europe
59	Mexico
60	Oceania
61	Philippines
62	South America
63	U.S. Possessions
64**	American Samoa
65**	Guam
66**	Saipan or Northern Mariana= 94 Army Post Office (APO AE) 95 Army Post Office (APO AA) 96 Army Post Office (APO AP)

22	Massachusetts	97**	Northern
23	Michigan		Marianas
24,77	Minnesota	98**	Guam
25	Mississippi	99**	American Samoa
26	Missouri		(with 000
27	Montana		county code;
28	Nebraska		otherwise
29	Nevada		unknown)
30	New Hampshire		
31	New Jersey		
32	New Mexico		
33	New York		
34	North Carolina		
35	North Dakota		
36,72	Ohio		
37	Oklahoma		
38	Oregon		
39,73	Pennsylvania		
40	Puerto Rico		
41	Rhode Island	** Pacific Territories	
42	South Carolina		
43	South Dakota		
44	Tennessee		
45,67,74	Texas		
46	Utah		

Attachment D

OCCURRENCES IN ACCOMMODATION DAYS:

1st Occurrence (177-179)	Private Room
2nd Occurrence (180-182)	Semi-Private Room
3rd Occurrence (183-185)	Ward
4th Occurrence (186-188)	Intensive Care
5th Occurrence (189-191)	Coronary Care

Attachment E

OCCURRENCES IN ACCOMMODATION CHARGES:

1st Occurrence (192-198)	Private Room
2nd Occurrence (199-205)	Semi-Private Room
3rd Occurrence (206-212)	Ward
4th Occurrence (213-219)	Intensive Care
5th Occurrence (220-226)	Coronary Care

Attachment F

OCCURRENCES IN SERVICE CHARGES:

1st Occurrence (227-233) is Other.
Revenue Center 002 through 099, 22X, 23X, 24X, 52X, 53X, 55X, 56X, 57X, 58X, 59X, 60X, 64X, 65X, 66X, 67X, 68X, 69X, 70X, 76X, 77X, 78X, 90X, 91X, 92X, 93X, 94X, 95X, 99X.

2nd Occurrence (234-240) is Pharmacy.
Revenue Center 25X, 26X, 63X.

3rd Occurrence (241-247) is Medical/Surgical Supplies.
Revenue Center 27X, 62X.

4th Occurrence (248-254) is Durable Medical Equipment.
Revenue Center 290, 291, 292.

5th Occurrence (255-261) is Used Durable Medical Equipment.
Revenue Center 293.

6th Occurrence (262-268) is Physical Therapy.
Revenue Center 42X.

7th Occurrence (269-275) is Occupational Therapy.
Revenue Center 43X.

8th Occurrence (276-282) is Speech Pathology.
Revenue Center 44X, 47X.

9th Occurrence (283-289) is Inhalation Therapy.
Revenue Center 41X, 46X.

10th Occurrence (290-296) is Blood.
Revenue Center 38X.

11th Occurrence (297-303) is Blood Administration.
Revenue Center 39X.

12th Occurrence (304-310) is Operating Room.
Revenue Center 36X, 71X, 72X.

13th Occurrence (311-317) is Lithotripsy.
Revenue Center 79X.

14th Occurrence (318-324) is Cardiology.
Revenue Center 48X, 73X.

15th Occurrence (325-331) is Anesthesia.
Revenue Center 37X.

16th Occurrence (332-338) is Laboratory.
Revenue Center 30X, 31X, 74X, 75X.

17th Occurrence (339-345) is Radiology.
Revenue Center 28X, 32X, 33X, 34X, 35X, 40X.

18th Occurrence (346-352) is MRI.
Revenue Center 61X.

19th Occurrence (353-359) is Outpatient Services.
Revenue Center 49X, 50X.

20th Occurrence (360-366) is Emergency Room.
Revenue Center 45X.

21st Occurrence (367-373) is Ambulance.
Revenue Center 54X.

22nd Occurrence (374-380) is Professional Fees.
Revenue Center 96X, 97X, 98X.

23rd Occurrence (381-387) is Organ Acquisition.
Revenue Center 81X, 89X.

24th Occurrence (388-394) is ESRD Revenue Setting.
Revenue Center 80X, 82X, 83X, 84X, 85X, 86X, 87X, 88X.

25th Occurrence (395-401) is Clinic Visit.
Revenue Center 51X.