MEDPAR 'R2K' Limited Dataset Record Layout - FY15 Proposed Rule
MedPAR consolidates Inpatient Hospital or Skilled Nursing Facility (SNF) claims data from the National Claims History (NCH) files into stay level records. The accumulation of claims submitted for the period commencing on a beneficiary's date of admission to an inpatient hospital or SNF and ending on the beneficiary's date of discharge from that hospital or SNF represents one stay. In the case of a SNF stay where the beneficiary has not yet been discharged and remains a patient, the claims submitted between the admission date to the SNF through the time of the MedPAR file creation, represent one stay. A stay record may represent one or more final action claims.
NOTE: Any given MedPAR file represents a static snapshot of a specific stay at the time the data was sourced from NCH. As such, any given stay record on a specific update of MedPAR DOES NOT NECESSARILY represent the final coding and/or payment information for that stay because if subsequent adjustments to the claims that comprise the stay occur after MedPAR is run, they will not be reflected on the file.

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FIELD	POSITION		Length	DESCRIPTION	DERIVATIONS	CODE TABLE
NCH Claim Type Code	1	2	2	The code used to identify the type of claim record being processed in NCH.	FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT	NCH_CLM_TYPE_TB
Beneficiary Age Count	14	16	3	The beneficiary's age as of date of admission.	This field is derived by subtracting the bene date of birth from the admission date, present on the first claim record included in the stay. Exception: If the resulting age is 64, and the MSC = 10 or 11, the age is changed to 65.	MEDPAR Beneficiary Age
Beneficiary Sex Code	17	17	1	The sex of a beneficiary.		BENE_SEX_IDENT_TB
Beneficiary Race Code	18	18	1	The race of a beneficiary.		BENE_RACE_TB
Beneficiary Medicare Status Code	19	20	2	The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).	CWF derives MSC from the following: 1. Date of birth 2. Claim through date 3. Original/Current reasons for entitlement 4. ESRD indicator 5. Beneficiary claim number Items 1,3,4,5 come from the CWF beneficiary master record; Item 2 comes from the FI/Carrier claim record.	BENE_MDCR_STUS_TB
Beneficiary Residence SSA Standard State Code	21	22	2	The SSA standard state code of a beneficiary's residence.		GEO_SSA_STATE_TB
Admission Day Code	35	35	1	The code indicating the day of the week on which the beneficiary was admitted to a facility.	This field is derived from the admission date that is present on the first claim record included in the stay.	MEDPAR_ADMSN_DAY_TB
Beneficiary Discharge Status Code	36	36	1	The code used to identify the status of the patient as of the CLM_THRU_DT.	This field is derived from the claim status code that is present on the last claim record included in the stay.	MEDPAR_BENE_DSCHRG_STUS_TB
GHO Paid Code	37	37	1	The code indicating whether or not a GHO has paid the provider for the claim(s).		MEDPAR_GHO_PD_TB
PPS Indicator Code	38	38	1	The code indicating whether or not the facility is being paid under the prospective payment system (PPS).	If the condition code not equal 65 on all of the claims included in the stay and the third position of the provider number is numeric set MEDPAR_PPS_IND_CD to 2 (PPS). Otherwise set it to 0 (Non PPS.)	MEDPAR_PPS_IND_TB
Organization NPI Number	39	48	10	ON AN INSTITUTIONAL CLAIM, THE NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER ASSIGNED TO UNIQUELY IDENTIFY THE INSTITUTIONAL PROVIDER CERTIFIED BY MEDICARE TO PROVIDE SERVICES TO THE BENEFICIARY.		
Provider Number Group	49	54	6			
Provider State Code	49	50	2	The first two positions of the provider number, identifying the state of the institutional provider that furnished services to the beneficiary during the stay.	This field comes from positions 1 & 2 of the provider number that is present on the first claim record included in the stay.	GEO_SSA_STATE_TB
Provider Number Third Position Code	51	51	1	The third position of the provider number, identifying the category of institutional provider that furnished services to the beneficiary during the stay.	This field is position 3 of the provider number from the first claim record included in the stay modified as follows: Where position 3 is an alpha character (S, T, U, W or Y) move to the MEDPAR provider special unit code and replace with a '0'. Where position 3 is an alpha character (M or R) move to the MEDPAR provider special unit code and replace with a '1'.	
Provider Number Serial Code	52	54	3	The last three positions of the provider number, identifying the specific serial numbers of the institutional provider that furnished services to the beneficiary during the stay.	This field comes from positions 4 - 6 of the provider number on the first claim record included in the stay.	
Provider Number Special Unit Code	55	55	1	The code identifying the special numbering system for units of hospitals that are excluded from PPS or hospitals with SNF swing-bed designation.	If the third position of the provider number from the first claim record included in the stay equals 'M', 'R', 'S', 'T', 'U', 'W', 'Y' OR 'Z', it is moved to this field, otherwise it is blank.	
Short Stay/Long Stay/SNF Indicator Code	56	56	1	The code indicating whether the stay is a short stay, long stay, or SNF.	This field is derived from the third position of the provider number that is present on the first claim record included in the stay.	
Stay Final Action Claims Count	57	59	3	The count of the number of claim records (final action) included in the stay.	This field is derived by counting the number of final action claims used to create the stay.	
Admission Date	88	94	7	The date the beneficiary was admitted for Inpatient care or the date that care started.	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 yea; 3YY = Third quarter of year; 4YY = Fourth quarter of year	
Discharge Date	95	101	7	The date on which the beneficiary was discharged or died.	This field specifies the date of the beneficiary's death or discharge from 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 yea; 3YY = Third quarter of year; 4YY = Fourth quarter of year	
Length of Stay Day Count	124	128	5	The count in days of the total length of a beneficiary's stay in a hospital or SNF.	This field is derived by subtracting the date of discharge (or thru date in SNF cases where beneficiary is still a patient) from the date of admission. If difference is '0,' the value becomes a '1.'	
Outlier Day Count	129	131	3	The count of the number of days paid as outliers (either a day or cost outlier) under PPS beyond the DRG threshold.	This field is derived by checking the MEDPAR utilization day count against the DRG threshold table (DRG weights file).	
Utilization Day Count	132	136	5	The count of the number of covered days of care that are chargeable to Medicare utilization for the stay.	This field is derived by accumulating the utilization day count that is present on any of the claim records included in the stay (i.e., the sum of utilization days reported on the claims that comprise the stay).	
Beneficiary Total Coinsurance Day Count	137	139	3	The count of the total number of coinsurance days involved with the beneficiary's stay in a facility. For Inpatient services, the beneficiary is liable for a daily coinsurance amount after the 60th day and before the 91st day in a single spell of illness; for SNF services, the beneficiary is liable for a daily coinsurance amount after the 20th day and before the 101st day in a single spell of illness.	This field is derived by accumulating the coinsurance day count that is present on any of the claim records included in the stay (i.e., the sum of coinsurance days reported on the claims that comprise the stay).	
Beneficiary LRD Used Count	140	142	3	The count of the number of lifetime reserve days (LRD) used by the beneficiary for this stay.	This field is derived by accumulating the lifetime reserve days used count that is present on any of the claim records included in the stay (i.e., the sum of LRD reported on the claims that comprise the stay).	
Beneficiary Part A Coinsurance Liability Amount	143	151	9	The amount of money (rounded to whole dollars) identified as the beneficiary's liability for part A coinsurance for the stay.		
Beneficiary Inpatient Deductible Liability Amount	152	160	9	The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the Inpatient deductible for the stay.		
Beneficiary Blood Deductible Liability Amount	161	169	9	The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the blood deductible for the stay.	This field is derived by accumulating the beneficiary blood deductible liability amount that is present on any of the claim records included in the stay (i.e., the sum of the blood deductibles reported on the claims that comprise the stay).	
Beneficiary Primary Payer Amount	170	178	9	The amount of payment (rounded to whole dollars) made on behalf of the beneficiary by a primary payer other than Medicare, which has been applied to the covered Medicare charges for the stay.	This field is derived by accumulating the beneficiary primary payer payment amount that is present on any of the claim records included in the stay (i.e., the sum of the primary payer amounts reported on the claims that comprise the stay).	
DRG Outlier Approved Payment Amount	179	187	9	The amount of additional payment (rounded to whole dollars) approved due to an outlier situation over the DRG allowance for the stay.	This field is derived by accumulating the DRG outlier approved payment amount (value code = 17 amount) that is present on any of the claim records included in the stay (i.e., the sum of outlier amounts reported on the claims that comprise the stay).	
Inpatient Disproportionate Share Amount	188	196	9	The amount paid over the DRG amount (rounded to whole dollars) for the disproportionate share hospital for the stay.	This field is derived by accumulating the value amount associated with value code = 18 that is present on any o the claim records included in the stay (i.e., the sum of value code 18 amounts reported on the claims that comprise the stay).	
Indirect Medical Education (IME) Amount	197	205	9	The amount of additional payment (rounded to whole dollars) made to teaching hospitals for IME for the stay.	This field is derived by accumulating the value amount associated with value code = 19 that is present on any of the claim records included in the stay (i.e., the sum of IME amounts - value code 19 amounts - reported on the claims that comprise the stay).	
DRG Price Amount	206	214	9	The amount (called the 'DRG price' for purposes of MEDPAR analysis) that would have been paid if no deductibles, coinsurance, primary payers, or outliers were involved (rounded to whole dollars).	This field is derived by accumulating the following amounts: MEDPAR Medicare payment amount, MEDPAR beneficiary primary payer payment amount, MEDPAR beneficiary coinsurance liability amount, MEDPAR beneficiary Inpatient deductible liability amount, MEDPAR beneficiary blood deductible amount; and then subtracting from the sum the MEDPAR DRG outlier approved payment amount.	
Total Pass Through Amount	215	223	9	The total of all claim pass through amounts (rounded to whole dollars) for the stay.	This field is derived by multiplying the pass thru per diem amount that is present on the last claim record included in the stay times the MEDPAR utilization day count (the sum of the utilization (covered) days reported on the claims that comprise the stay).	
Total PPS Capital Amount	224	232	9	The total amount (rounded to whole dollars) that is payable for capital PPS (e.g., reimbursement for depreciation, rent, certain interest, real estate taxes for hospital buildings/equipment subject to PPS).	This field is derived by accumulating the total PPS capital amount that is present on any of the claim records included in the stay (i.e., the sum of total PPS capital amounts reported on the claims that comprise the stay).	
Inpatient Low Volume Payment Amount	233	241	9	The amount field used to identify a payment adjustment given to hospitals to account for the higher costs per discharge for low income hospitals under the Inpatient Prospective Payment System (IPPS).	This field is derived by accumulating the IP Low Volume Amount that is present on any of the claim records included in the stay (i.e. the sum of the low volume amounts re- ported on the claims that comprise the stay).	
Total Charge Amount	242	250	9	The total amount (rounded to whole dollars) of all charges (covered and noncovered) for all services provided to the beneficiary for the stay.	This field is derived by accumulating the total charge amount from all claim records included in the stay (i.e. the sum of total charges reported on the claims that comprise the stay).	
Total Covered Charge Amount	251	259	9	The portion of the total charges amount (rounded to whole dollars) that is covered by Medicare for the stay.	This field is derived by calculating the covered charges from all claim records included in the stay (i.e., subtract the revenue center noncovered charge amount from the revenue center total charge amount for revenue center code = 0001 that is reported on the claims that comprise the stay; sum the results). Exception: if there exists an erroneous condition relative to revenue center code 0001, the calculation will be made for each revenue center code included on the claims that comprise the stay with the results summed to create the total.	

Medicare Payment Amount	260	268	9	Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the fi; and represents what was paid to the institutional provider, with the exceptions noted below. **Note: in some situations, a negative claim payment amount May be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.) Under ip PPS, Inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the pricer program. On the ip PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), in- direct medical education (since 10/1/88), total PPS capital (since 10/1/91). It does not include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement. Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as rugs III. For the SNF PPS claim, the SNF pricer will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount. Exceptions: For claims involving demos and bba encounter data, the amount reported in this field May not just represent the actual provider payment. For demo ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included. For demo ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under ffs, instead of the actual pay- ment to the MCO. For demo ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both part a and part B services. To identify what the conventional provider part a payment would have been, check value code = 'y4'. For bba encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under ffs, instead of the actual payment to the bba plan.	This field is derived by accumulating the payment amount that is present on all of the claim records included in the stay (i.e, the sum of payment (reimbursement) reported on the claims that comprise the stay).	
All Accommodations Total Charge Amount	269	277	9	The total charge amount (rounded to whole dollars) for all accommodations (routine hospital room and board charges for general care, coronary care and/or intensive care units) related to a beneficiary's stay.	This field is the sum of MEDPAR private room charge amount, MEDPAR semiprivate room charge amount, MEDPAR ward charge amount, MEDPAR intensive care charge amount, and MEDPAR coronary care charge amount (i.e., the accumulation of the revenue center total charge amount associated with revenue center codes 0100 - 0219 from all claim records included in the stay).	
Departmental Total Charge Amount	278	286	9	The total charge amount (rounded to whole dollars) for all ancillary departments (other than routine room and board, CCU, and ICU) related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0220 - 0999 from all claim records included in the stay (i.e, the sum of charges for all revenue centers other than accommodations 0100 - 0219).	
Private Room Day Count	287	289	3	The count of the number of private room days used by the beneficiary for the stay.	This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 011x and 014x from all claim records included in the stay. Exception for SNF rugs demo eff 3/96 SNF update: field is derived from revenue center codes in the 9033-9044 series.	
Semiprivate Room Day Count	290	292	3	The count of the number of semi-private room days used by the beneficiary for the stay.	This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 010X, 012X, 013X, 016X - 019X from all claim records included in the stay. Exception for SNF rugs demo eff 3/96 SNF update: field is derived from revenue center codes in the 9019-9032 series.	
Ward Day Count	293	295	3	The count of the number of ward days used by the beneficiary for the stay.	This field is derived by accumulating the revenue center unit count associated with accommodation revenue center code 015x from all claim records included in the stay. Exception for SNF rugs demo eff 3/96 SNF update: field is derived from revenue center codes in the 9000-9018 series.	
Intensive Care Day Count	296	298	3	The count of the number of intensive care days used by the beneficiary for the stay.	This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 020X (all 9 subcategories) from all claims included in the stay. LIMITATIONS: There is approximately a 20% error rate in the revenue center code category 0206 due to coders misunderstanding the term 'post ICU' as including any day after an ICU stay rather than just days in a step-down/lower case version of an ICU. 'Post' was removed from the revenue center code 0206 description, effective 10/1/96 (12/96 MEDPAR update). 0206 Is now defined as 'intermediate ICU'.	
Coronary Care Day Count	299	301	3	The count of the number of coronary care days used by the beneficiary for the stay.	This field is derived by accumulating the revenue center unit count associated with accommodation revenue center code 021x (all six subcategories) from all claim records included in the stay. LIMITATIONS: There is approximately a 20% error rate in the revenue center code category 0214 due to coders misunderstanding the term 'post ccu' as including any day after a ccu stay rather than just days in a step-down/lower case version of a ccu. 'Post' was removed from the revenue center code 0214 description, effective 10/1/96 (12/96 MEDPAR update). 0214 Is now defined as 'intermediate ccu'.	
Private Room Charge Amount	302	310	9	The charge amount (rounded to whole dollars) for private room accommodations related to a beneficiary's stay.	THIS FIELD IS DERIVED BY ACCUMULATING THE REVENUE CENTER TOTAL CHARGE AMOUNT ASSOCIATED WITH REVENUE CENTER CODES 011X AND 014X FROM ALL CLAIM RECORDS INCLUDED IN THE STAY. EXCEPTION FOR SNF RUGS DEMO EFF 3/96 SNF UPDATE: FIELD IS DERIVED FROM REVENUE CENTER CODES IN THE 9033-9044 SERIES.	
Semi-Private Room Charge Amount	311	319	9	The charge amount (rounded to whole dollars) for semi- private room accommodations related to a beneficiary's stay.	THIS FIELD IS DERIVED BY ACCUMULATING THE REVENUE CENTER TOTAL CHARGE AMOUNT ASSOCIATED WITH REVENUE CENTER CODES 010X, 012X, 013X, AND 016X - 019X FROM ALL CLAIM RECORDS INCLUDED IN THE STAY. EXCEPTION FOR SNF RUGS DEMO EFF 3/96 SNF UPDATE: FIELD IS DERIVED FROM REVENUE CENTER CODES IN THE 9019-9032 SERIES.	
Ward Charge Amount	320	328	9	The charge amount (rounded to whole dollars) for ward accommodations related to a beneficiary's stay.	This field is derived by accumulating the revenue total charge amount associated with revenue cente r code 015x from all claim records included in the Exception for SNF rugs demo eff 3/96 SNF update: field is derived from revenue center codes in the 9000-9018 series.	
Intensive Care Charge Amount	329	337	9	The charge amount (rounded to whole dollars) for intensive care accommodations related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with accommodation revenue center code 020x from all claim records included in the stay.	
Coronary Care Charge Amount	338	346	9	The charge amount (rounded to whole dollars) for coronary care accommodations related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with accommodation revenue center code 021X from all claim records included in the stay.	
Other Service Charge Amount	347	355	9	The charge amount (rounded to whole dollars) for other services (revenue centers that do not fit into other categories) related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with the 'other' revenue center codes from all claim records included in the stay the 'other' codes include 0002-0099, 022x, 023x, 024x, 052x, 053x, 055x - 060x, 064x - 070x, 076x - 078x, 090x 095x, and 099x. (Some of these codes are not yet assigned.)	
Pharmacy Charge Amount	356	364	9	The charge amount (rounded to whole dollars) for pharmaceutical costs related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 025x, 026x, and 063x from all claims records included in the stay.	
Medical/Surgical Supply Charge Amount	365	373	9	The charge amount (rounded to whole dollars) for medical/surgical supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 027x and 062x from all claim records included in the stay.	
DME Charge Amount	374	382	9	The charge amount (rounded to whole dollars) for DME (purchase of new DME and rentals) related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0290, 0291, 0292, and 0294 - 0299 from all claim records included in the stay.	
Used DME Charge Amount	383	391	9	The charge amount (rounded to whole dollars) for used DME (purchase of used DME) related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 0293 from all claim records included in the stay.	
Physical Therapy Charge Amount	392	400	9	The charge amount (rounded to whole dollars) for physical therapy services provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 042x from all claims records included in the stay.	
Occupational Therapy Charge Amount	401	409	9	The charge amount (rounded to whole dollars) for occupational therapy services provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 043x from all claims records included in the stay.	
Speech Pathology Charge Amount	410	418	9	The charge amount (rounded to whole dollars) for speech pathology services (speech, language, audiology) provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 044x and 047x from all claim records included in the stay.	
Inhalation Therapy Charge Amount	419	427	9	The charge amount (rounded to whole dollars) for inhalation therapy services (respiratory and pulmonary function) provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 041x and 046x from all claim records included in the stay.	
Blood Charge Amount	428	436	9	The charge amount (rounded to whole dollars) for blood provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 038x from all claim records included in the stay.	
Blood Administration Charge Amount	437	445	9	The charge amount (rounded to whole dollars) for blood storage and processing related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 039x from all claim records included in the stay.	
Operating Room Charge Amount	446	454	9	The charge amount (rounded to whole dollars) for the operating room, recovery room, and labor room delivery used by the beneficiary during the stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 036X, 071X, and 072X from all claim records included in the stay.	
Lithotripsy Charge Amount	455	463	9	The charge amount (rounded to whole dollars) for lithotripsy services provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 079X from all claim records included in the stay.	
Cardiology Charge Amount	464	472	9	The charge amount (rounded to whole dollars) for cardiology services and electrocardiogram(s) provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 048X and 073X from all claim records included in the stay.	
Anesthesia Charge Amount	473	481	9	The charge amount (rounded to whole dollars) for anesthesia services provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 037X from all claim records included in the stay.	

Laboratory Charge Amount	482	490	9	The charge amount (rounded to whole dollars) for laboratory costs related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 030x, 031x, 074x, and 075x from all claim records included in the stay.	
Radiology Charge Amount	491	499	9	The charge amount (rounded to whole dollars) for radiology costs (including oncology, excluding MRI) related to a beneficiary's stay.	This field is derived by accumulating revenue center total charge amount associated with revenue center codes 028x, 032x, 033x, 034x, 035x, and 040x from all claim records included in the stay.	
MRI Charge Amount	500	508	9	The charge amount (rounded to whole dollars) for MRI services provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center 061x from all claim records included in the stay.	
Outpatient Service Charge Amount	509	517	9	The charge amount (rounded to whole dollars) for outpatient services provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 049x and 050x from all claim records included in the stay.	
Emergency Room Charge Amount	518	526	9	The charge amount (rounded to whole dollars) for emergency room services provided during the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 045X from all claim records included in the stay.	
Ambulance Charge Amount	527	535	9	The charge amount (rounded to whole dollars) for ambulance services related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 054x from all claim records included in the stay.	
Professional Fees Charge Amount	536	544	9	The charge amount (rounded to whole dollars) for professional fees related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 096x, 097x, and 098x from all claims records included in the stay.	
Organ Acquisition Charge Amount	545	553	9	The charge amount (rounded to whole dollars) for organ acquisition or other donor bank services related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 081x and 089x from all claim records included in the stay.	
ESRD Revenue Setting Charge Amount	554	562	9	The charge amount (rounded to whole dollars) for ESRD services (other than organ acquisition and other donor bank) related to a beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 080x, 082x - 088x from all claim records included in the stay.	
Clinic Visit Charge Amount	563	571	9	The charge amount (rounded to whole dollars) for clinic visits (e.g., visits to chronic pain or dental centers or to clinics providing psychiatric, ob-gyn, pediatric services) related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount associated with revenue center code 051x from all claim records included in the stay.	
Intensive Care Unit (ICU) Indicator Code	572	572	1	The code indicating that the beneficiary has spent time under intensive care during the stay. It also specifies the type of ICU.	This field is derived by checking for the presence of icu revenue center codes (listed below) on any of the claim records included in the stay. If more than one of the revenue center codes listed below are included on these claims, the code with the highest revenue center total charge amount is used. LIMITATIONS: There is approximately a 20% error rate in the revenue center code category 0206 due to coders misunderstanding the term 'post ICU' as including any day after an ICU stay rather than just days in a step-down/lower case version of an ICU. 'Post' was removed from the revenue center code 0206 description, effective 10/1/96 (12/96 MEDPAR update). 0206 Is now defined as 'intermediate ICU'.	MEDPAR_ICU_IND_TB
Coronary Care Indicator Code	573	573	1	The code indicating that the beneficiary has spent time under coronary care during the stay. It also specifies the type of coronary care unit.	This field is derived by checking for the presence of coronary care revenue center codes (listed below) on any of the claim records included in the stay. If more than one of the revenue center codes listed below are included on these claims, the code with the highest revenue center total charge amount is used. LIMITATIONS: There is approximately a 20% error rate in the revenue center code category 0214 due to coders misunderstanding the term 'post CCU' as including any day after a CCU stay rather than just days in a step-down/lower case version of a CCU. 'Post' was removed from the revenue center code 0214 description, effective 10/1/96 (12/96 MEDPAR update). 0214 Is now defined as 'intermediate CCU'.	MEDPAR_CRNRY_CARE_IND_TB
Pharmacy Indicator Code	574	574	1	The code indicating whether or not the beneficiary received drugs during the stay. It also specifies the type of drugs.	This field is derived by checking for the presence of drug-specific revenue center codes (listed below) on any of the claim records included in the stay.	MEDPAR_PHRMCY_IND_TB
Transplant Indicator Code	575	575	1	The code indicating whether or not the beneficiary received a organ transplant during the stay.	This field is derived by checking for the presence of the transplant revenue center code (listed below) on any of the claim records included in the stay.	MEDPAR_TRNSPLNT_IND_TB
Radiology Oncology Indicator Switch	576	576	1	The switch indicating whether or not the beneficiary received radiology oncology services during the stay.	This field is derived by checking for revenue center code 028X on any of the claim records included in the stay.	MEDPAR_RDLGY_ONCLGY_IND_TB
Radiology Diagnostic Indicator Switch	577	577	1	The switch indicating whether or not the beneficiary received radiology diagnostic services during the stay.	This field is derived by checking for revenue center code 032x on any of the claim records included in the stay.	MEDPAR_RDLGY_DGNSTC_IND_TB
Radiology Therapeutic Indicator Switch	578	578	1	The switch indicating whether or not the beneficiary received radiology therapeutic services during the stay.	This field is derived by checking for revenue center code 033X on any of the claim records included in the stay.	MEDPAR_RDLGY_THRPTC_IND_TB
Radiology Nuclear Medicine Indicator Switch	579	579	1	The switch indicating whether or not the beneficiary received radiology nuclear medicine services during the stay.	This field is derived by checking for revenue center code 034x on any of the claim records included in the stay.	MEDPAR_RDLGY_NUCLR_MDCN_IND_TB
Radiology CT Scan Indicator Switch	580	580	1	The switch indicating whether or not the beneficiary received radiology computed tomographic (CT) scan services during the stay.	This field is derived by checking for revenue center code 035X on any of the claim records included in the stay.	MEDPAR_RDLGY_CT_SCAN_IND_TB
Radiology Other Imaging Indicator Switch	581	581	1	The switch indicating whether or not the beneficiary received radiology other imaging services during the stay.	This field is derived by checking for revenue center code 040X on any of the claim records included in the stay.	MEDPAR_RDLGY_OTHR_IMGNG_IND_TB
Outpatient Services Indicator Code	582	582	1	The code indicating whether or not the beneficiary has received outpatient services, ambulatory surgical care, or both.	This field is derived by checking for the presence of the outpatient services revenue center codes listed below on any of the claim records included in the stay.	MEDPAR_OP_SRVC_IND_TB
Organ Acquisition Indicator Code	583	584	2	The code indicating the type of organ acquisition received by the beneficiary during the stay.	This field is derived by checking for the presence of the organ acquisition indicator revenue center codes listed below on any of the claim records included in the stay.	MEDPAR_ORGN_ACQSTN_IND_TB
ESRD Setting Indicator Code	585	586	2	The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present.	This field is derived from the presence of the dialysis revenue center codes listed below on any of the claim records included in the stay.	MEDPAR_ESRD_SETG_IND_TB
ESRD Setting Indicator Code 2	587	588	2	The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present.	This field is derived from the presence of the dialysis revenue center codes listed below on any of the claim records included in the stay.	MEDPAR_ESRD_SETG_IND_TB
ESRD Setting Indicator Code 3	589	590	2	The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present.	This field is derived from the presence of the dialysis revenue center codes listed below on any of the claim records included in the stay.	MEDPAR_ESRD_SETG_IND_TB
ESRD Setting Indicator Code 4	591	592	2	The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present.	This field is derived from the presence of the dialysis revenue center codes listed below on any of the claim records included in the stay.	MEDPAR_ESRD_SETG_IND_TB
ESRD Setting Indicator Code 5	593	594	2	The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present.	This field is derived from the presence of the dialysis revenue center codes listed below on any of the claim records included in the stay.	MEDPAR_ESRD_SETG_IND_TB
Claim Present on Admission Diagnosis Code Count	595	596	2	Effective with Version 'J', the count of the number of Present on Admission (POA) codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many claim POA diagnosis trailers are present.		
Claim Present on Admission Diagnosis Indicator Code	597	597	1	Effective with Version 'J', the code used to identify the present on admission(POA) indicator code associated with the diagnosis codes (principal and secondary). The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.		CLM_POA_IND_TB
Claim Present on Admission Diagnosis Indicator Code 2	598	598	1			
Claim Present on Admission Diagnosis Indicator Code 3	599	599	1			
Claim Present on Admission Diagnosis Indicator Code 4	600	600	1			
Claim Present on Admission Diagnosis Indicator Code 5	601	601	1			
Claim Present on Admission Diagnosis Indicator Code 6	602	602	1			
Claim Present on Admission Diagnosis Indicator Code 7	603	603	1			
Claim Present on Admission Diagnosis Indicator Code 8	604	604	1			
Claim Present on Admission Diagnosis Indicator Code 9	605	605	1			
Claim Present on Admission Diagnosis Indicator Code 10	606	606	1			
Claim Present on Admission Diagnosis Indicator Code 11	607	607	1			
Claim Present on Admission Diagnosis Indicator Code 12	608	608	1			
Claim Present on Admission Diagnosis Indicator Code 13	609	609	1			
Claim Present on Admission Diagnosis Indicator Code 14	610	610	1			
Claim Present on Admission Diagnosis Indicator Code 15	611	611	1			
Claim Present on Admission Diagnosis Indicator Code 16	612	612	1			
Claim Present on Admission Diagnosis Indicator Code 17	613	613	1			
Claim Present on Admission Diagnosis Indicator Code 18	614	614	1			
Claim Present on Admission Diagnosis Indicator Code 19	615	615	1			
Claim Present on Admission Diagnosis Indicator Code 20	616	616	1			
Claim Present on Admission Diagnosis Indicator Code 21	617	617	1			
Claim Present on Admission Diagnosis Indicator Code 22	618	618	1			
Claim Present on Admission Diagnosis Indicator Code 23	619	619	1			
Claim Present on Admission Diagnosis Indicator Code 24	620	620	1			
Claim Present on Admission Diagnosis Indicator Code 25	621	621	1			
Claim Present on Admission Diagnosis E Code Count	672	673	2	Effective with Version 'J', the count of the number of Present on Admission (POA) codes associated with the diagnosis E codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many claim POA diagnosis E trailers are present.		

Claim Present on Admission Diagnosis E Indicator Code	674	674	1	Effective with Version 'J', the code used to identify the present on admission(POA) indicator code associated with the diagnosis E codes.		
Claim Present on Admission Diagnosis E Indicator Code 2	675	675	1			
Claim Present on Admission Diagnosis E Indicator Code 3	676	676	1			
Claim Present on Admission Diagnosis E Indicator Code 4	677	677	1			
Claim Present on Admission Diagnosis E Indicator Code 5	678	678	1			
Claim Present on Admission Diagnosis E Indicator Code 6	679	679	1			
Claim Present on Admission Diagnosis E Indicator Code 7	680	680	1			
Claim Present on Admission Diagnosis E Indicator Code 8	681	681	1			
Claim Present on Admission Diagnosis E Indicator Code 9	682	682	1			
Claim Present on Admission Diagnosis E Indicator Code 10	683	683	1			
Claim Present on Admission Diagnosis E Indicator Code 11	684	684	1			
Claim Present on Admission Diagnosis E Indicator Code 12	685	685	1			
Diagnosis Code Count	736	737	2	The count of the number of diagnosis codes included in the stay.	This field is derived by adding '1' to the count of the other diagnosis codes reported on the last claim record included in the stay. The '1' represents the principal diagnosis code, which is reported separately from the other diagnosis.	
Diagnosis Version Code	738	738	1	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.		CLM_DGNS_VRSN_TB
Diagnosis Version Code 2	739	739	1			
Diagnosis Version Code 3	740	740	1			
Diagnosis Version Code 4	741	741	1			
Diagnosis Version Code 5	742	742	1			
Diagnosis Version Code 6	743	743	1			
Diagnosis Version Code 7	744	744	1			
Diagnosis Version Code 8	745	745	1			
Diagnosis Version Code 9	746	746	1			
Diagnosis Version Code 10	747	747	1			
Diagnosis Version Code 11	748	748	1			
Diagnosis Version Code 12	749	749	1			
Diagnosis Version Code 13	750	750	1			
Diagnosis Version Code 14	751	751	1			
Diagnosis Version Code 15	752	752	1			
Diagnosis Version Code 16	753	753	1			
Diagnosis Version Code 17	754	754	1			
Diagnosis Version Code 18	755	755	1			
Diagnosis Version Code 19	756	756	1			
Diagnosis Version Code 20	757	757	1			
Diagnosis Version Code 21	758	758	1			
Diagnosis Version Code 22	759	759	1			
Diagnosis Version Code 23	760	760	1			
Diagnosis Version Code 24	761	761	1			
Diagnosis Version Code 25	762	762	1			
Diagnosis Code	763	769	7	The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).		
Diagnosis Code 2	770	776	7			
Diagnosis Code 3	777	783	7			
Diagnosis Code 4	784	790	7			
Diagnosis Code 5	791	797	7			
Diagnosis Code 6	798	804	7			
Diagnosis Code 7	805	811	7			
Diagnosis Code 8	812	818	7			
Diagnosis Code 9	819	825	7			
Diagnosis Code 10	826	832	7			
Diagnosis Code 11	833	839	7			
Diagnosis Code 12	840	846	7			
Diagnosis Code 13	847	853	7			
Diagnosis Code 14	854	860	7			
Diagnosis Code 15	861	867	7			
Diagnosis Code 16	868	874	7			
Diagnosis Code 17	875	881	7			
Diagnosis Code 18	882	888	7			
Diagnosis Code 19	889	895	7			
Diagnosis Code 20	896	902	7			
Diagnosis Code 21	903	909	7			
Diagnosis Code 22	910	916	7			
Diagnosis Code 23	917	923	7			
Diagnosis Code 24	924	930	7			
Diagnosis Code 25	931	937	7			
Diagnosis E Code Count	988	989	2	Effective with Version 'J', the count of the number of diagnosis E codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many diagnosis E trailers are present.		
Diagnosis E Version Code	990	990	1	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.		CLM_DGNS_VRSN_TB
Diagnosis E Version Code 2	991	991	1			
Diagnosis E Version Code 3	992	992	1			
Diagnosis E Version Code 4	993	993	1			
Diagnosis E Version Code 5	994	994	1			
Diagnosis E Version Code 6	995	995	1			
Diagnosis E Version Code 7	996	996	1			
Diagnosis E Version Code 8	997	997	1			
Diagnosis E Version Code 9	998	998	1			
Diagnosis E Version Code 10	999	999	1			
Diagnosis E Version Code 11	1000	1000	1			
Diagnosis E Version Code 12	1001	1001	1			
Diagnosis E Code	1002	1008	7	Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.		
Diagnosis E Code 2	1009	1015	7			
Diagnosis E Code 3	1016	1022	7			
Diagnosis E Code 4	1023	1029	7			
Diagnosis E Code 5	1030	1036	7			
Diagnosis E Code 6	1037	1043	7			
Diagnosis E Code 7	1044	1050	7			
Diagnosis E Code 8	1051	1057	7			
Diagnosis E Code 9	1058	1064	7			
Diagnosis E Code 10	1065	1071	7			
Diagnosis E Code 11	1072	1078	7			

Diagnosis E Code 12	1079	1085	7			
Surgical Procedure Indicator Switch	1136	1136	1	The switch indicating whether or not there were any surgical procedures performed during the beneficiary's stay.	This field is derived by checking for the presence of procedure codes on the last claim record included in the stay.	MEDPAR_SRGCL_PRCDR_IND_TB
Surgical Procedure Code Count	1137	1138	2	The count of the number of surgical procedure codes included in the stay.	This field is derived by counting the procedure codes that are reported on the last claim record included in the stay.	
Surgical Procedure Performed Day Count	1139	1140	2	The count of the number of dates associated with the surgical procedures included in the stay.	This field is derived by counting the surgical procedures dates that are reported on the last claim record included in the stay.	
Surgical Procedure Version Code	1141	1141	1	Effective with Version 'J', the code used to indicate if the surgical procedure code is ICD-9 or ICD-10.		CLM_PRCDR_VRSN_TB
Surgical Procedure Version Code 2	1142	1142	1			
Surgical Procedure Version Code 3	1143	1143	1			
Surgical Procedure Version Code 4	1144	1144	1			
Surgical Procedure Version Code 5	1145	1145	1			
Surgical Procedure Version Code 6	1146	1146	1			
Surgical Procedure Version Code 7	1147	1147	1			
Surgical Procedure Version Code 8	1148	1148	1			
Surgical Procedure Version Code 9	1149	1149	1			
Surgical Procedure Version Code 10	1150	1150	1			
Surgical Procedure Version Code 11	1151	1151	1			
Surgical Procedure Version Code 12	1152	1152	1			
Surgical Procedure Version Code 13	1153	1153	1			
Surgical Procedure Version Code 14	1154	1154	1			
Surgical Procedure Version Code 15	1155	1155	1			
Surgical Procedure Version Code 16	1156	1156	1			
Surgical Procedure Version Code 17	1157	1157	1			
Surgical Procedure Version Code 18	1158	1158	1			
Surgical Procedure Version Code 19	1159	1159	1			
Surgical Procedure Version Code 20	1160	1160	1			
Surgical Procedure Version Code 21	1161	1161	1			
Surgical Procedure Version Code 22	1162	1162	1			
Surgical Procedure Version Code 23	1163	1163	1			
Surgical Procedure Version Code 24	1164	1164	1			
Surgical Procedure Version Code 25	1165	1165	1			
Surgical Procedure Code	1166	1172	7	The ICD-9-CM code identifying the principal or other surgical procedure performed during the beneficiary's stay. This element is part of the MEDPAR surgical procedure group. It may occur up to 6 times.	This field is the actual principal surgical procedure code (1st occurrence) or one of up to 5 other surgical procedure codes that may be present on the last claim record included in the stay.	
Surgical Procedure Code 2	1173	1179	7			
Surgical Procedure Code 3	1180	1186	7			
Surgical Procedure Code 4	1187	1193	7			
Surgical Procedure Code 5	1194	1200	7			
Surgical Procedure Code 6	1201	1207	7			
Surgical Procedure Code 7	1208	1214	7			
Surgical Procedure Code 8	1215	1221	7			
Surgical Procedure Code 9	1222	1228	7			
Surgical Procedure Code 10	1229	1235	7			
Surgical Procedure Code 11	1236	1242	7			
Surgical Procedure Code 12	1243	1249	7			
Surgical Procedure Code 13	1250	1256	7			
Surgical Procedure Code 14	1257	1263	7			
Surgical Procedure Code 15	1264	1270	7			
Surgical Procedure Code 16	1271	1277	7			
Surgical Procedure Code 17	1278	1284	7			
Surgical Procedure Code 18	1285	1291	7			
Surgical Procedure Code 19	1292	1298	7			
Surgical Procedure Code 20	1299	1305	7			
Surgical Procedure Code 21	1306	1312	7			
Surgical Procedure Code 22	1313	1319	7			
Surgical Procedure Code 23	1320	1326	7			
Surgical Procedure Code 24	1327	1333	7			
Surgical Procedure Code 25	1334	1340	7			
Blood Pints Furnished Quantity	1566	1568	3	The quantity of blood (number of whole pints) furnished to the beneficiary during the stay. Note: this includes blood pints replaced as well as not replaced.	This field is derived by accumulating the blood pints furnished quantity from all claim records included in the stay.	
DRG Code	1571	1573	3	The code indicating the DRG to which the claims that comprise the stay belong for payment purposes.	This field comes from the actual DRG code that is present on the last claim record included in the stay. exception: if the DRG code is not present (e.g., claims from Maryland and PPS-exempt hospital units do not have a DRG), a valid DRG is obtained using the grouper software and is moved to this field.	
Discharge Destination Code	1574	1575	2	The code primarily indicating the destination of the beneficiary upon discharge from a facility; also denotes death or SNF/still patient situations.	This field comes from the claim status code that is present on the last claim record included in the stay.	PTNT_DSCHRG_STUS_TB
DRG/Outlier Stay Code	1576	1576	1	The code identifying (1) for PPS providers if the stay has an unusually long length (day outlier) or high cost (cost outlier); or (2) for non-PPS providers the source for developing the DRG.	This field is the actual DRG outlier stay code that is present on the last claim record included in the stay. Applicable to PPS providers: 0 = No Outlier 1 = Day Outlier 2 = Cost Outlier Applicable to Non-PPS Providers: 6 = Valid DRG Received From Intermediary 7 = HCFA-Developed DRG 8 = HCFA-Developed DRG Using Claim Status Code 9 = Not Groupable	
Beneficiary Primary Payer Code	1577	1577	1	The code indicating the type of payer who has primary responsibility for the payment of the Medicare beneficiary's claims related to the stay.	This field comes from the primary payer code that is present on the first claim record included in the stay.	MEDPAR_BENE_PRMRY_PYR_TB
ESRD Condition Code	1578	1579	2	The code indicating if the beneficiary had an ESRD condition reported during the stay.	This field is derived by checking for condition codes 70 - 76 on any of the claim records included in the stay.	MEDPAR_ESRD_COND_TB
Source Inpatient Admission Code	1580	1580	1	The code indicating the source of the beneficiary's admission to an Inpatient facility or, for newborn admission, the type of delivery.	This field comes from the source Inpatient admission code that is present on the last claim record included in the stay.	CLM_SRC_IP_ADMSN_TB
Inpatient Admission Type Code	1581	1581	1	The code indicating the type and priority of the beneficiary's admission to a facility for the Inpatient hospital stay.	This field comes from the Inpatient admission type code that is present on the last claim record included in the stay.	
Fiscal Intermediary/Carrier Identification Number	1582	1586	5	The identification of the intermediary processing the beneficiary's claims related to the stay.		
Admitting Diagnosis Version Code	1587	1587	1	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.		CLM_ADMTG_DGNS_VRSN_TB
Admitting Diagnosis Code	1588	1594	7	The ICD code indicating the beneficiary's initial diagnosis at the time of admission.		
Admission Death Day Count	1595	1599	5	The count of the number of days from the date the beneficiary was admitted to a facility to the beneficiary's date of death (DOD).	This field is derived by counting the number of days between the MEDPAR admission date (the admission date present on the first claim record included in the stay) and MEDPAR beneficiary death date (the death date present on the enrollment database, which is accessed prior to creation of the quarterly MEDPAR file).	
Care Improvement Model 1 Code	1624	1625	2	Effective with CR#7, the code used to identify that the care improvement model 1 is being used for bundling payments. The valid value for care improvement model 1 is '61'. This value is also reflected in the demonstration trailer.	This field comes from the Claim Care Improvement Model (CLM- CARE-IMPRVMT-MODEL-1-CD) code that is present on the first claim record included in the stay. If there is no Claim Care Improve Model code on the 1st claim then take the first found code on a the other claims that make up the stay.	CLM_CARE_IMPRVMT_MODEL_TB
Care Improvement Model 2 Code	1626	1627	2	Effective with CR#7, the code used to identify that the care improvement model 2 is being used for bundling payments. The valid value for care improvement model 2 is '62'. This value is also reflected in the demonstration trailer.	This field comes from the Claim Care Improvement Model (CLM- CARE-IMPRVMT-MODEL-2-CD) code that is present on the first claim record included in the stay. If there is no Claim Care Improvement Model code on the 1st claim then take the first found code on any of the other claims that make up the stay.	CLM_CARE_IMPRVMT_MODEL_TB
Care Improvement Model 3 Code	1628	1629	2	Effective with CR#7, the code used to identify that the care improvement model 3 is being used for bundling payments. The valid value for care improvement model 3 is '63'. This value is also reflected in the demonstration trailer.	This field comes from the Claim Care Improvement Model (CLM- CARE-IMPRVMT-MODEL-3-CD) code that is present on the first claim record included in the stay. If there is no Claim Care Improvement Model code on the 1st claim then take the first found code on any of the other claims that make up the stay.	CLM_CARE_IMPRVMT_MODEL_TB
Care Improvement Model 4 Code	1630	1631	2	Effective with CR#7, the code used to identify that the care improvement model 4 is being used for bundling payments. The valid value for care improvement model 4 is '64'. This value is also reflected in the demonstration trailer.	This field comes from the Claim Care Improvement Model (CLM- CARE-IMPRVMT-MODEL-4-CD) code that is present on the first claim record included in the stay. If there is no Claim Care Improvement Model code on the 1st claim then take the first found code on any of the other claims that make up the stay.	CLM_CARE_IMPRVMT_MODEL_TB

VBP Participant Indicator Code	1632	1632	1	The code used to identify a reason a hospital is excluded from the Hospital Value Based Purchasing (HVBP) progam. The ACA (Section 3001) excludes from HVBP program hospitals that meet certain conditions.	This field comes from the Claim VBP Participant Indicator code (CLM-VBP-PRTCPNT- IND-CD) that is present on the first claim record included in the stay. If there is no Claim VBP Participant Indicator code on the first claim then take the first found code on any of the other claims that make up the stay.	CLM_VBP_PRTCPNT_IND_TB
HRR Participant Indicator Code	1633	1633	1	The code used to identify whetherthe facility is participating in the Hospital Readmission Reduction Program.	This field comes from the Claim HRR Participant Indicator code (CLM-HRR- PRTCPNT-IND-CD) that is present on the first claim record included in the stay. If there is no Claim HRR Participant Indicator code on the first claim then take the first found code on any of the other claims that make up the stay.	CLM_HRR_PRTCPNT_IND_TB
Bundled Model Discount Percent	1634	1635	2	The field used to identify the discount percentage that will be applied to the payment for all of the hospitals' DRG over the lifetime of the initiative. The hospital must be participating in the Model 1 Bundled Payments for Care Improvement initiative.	This field comes from the Claim Bundled Model Discount (CLM-BNDLD-MODEL-1-DSCNT-PCT) that is present on the last record included in the stay.	
VBP Adjustment Percent	1636	1647	12	Under the Hospital Value Based Purchasing (HVBP) program, the percent used to identify an adjustment made to certain subsection (d) IPPS hospitals base operating DRG amount, in accordance with their Total Performance Score (TPS) as required by the Affordable Care Act (ACA). This is the Value Based Purchasing Score.	This field comes from the Claim VBP Adjustment Percent (CLM-VBP-CLM- ADJSTMT-PCT) that is present on the last claim record included in the stay.	
HRR Adjustment Percent	1648	1652	5	Under the Hospital Readmission Reduction (HRR) Program, the percent used to identify the readmission adjustment factor that will be applied in determining a 'subsection (d) hospital's operating IPPS payment amount in accordance with Section 3025 of the Affordable Care Act (ACA).	This field comes from the Claim HRR Adjustment Percent (CLM-HRR-ADJSTMT-PCT) that is present on the last claim record included in the stay.	
Informational Encounter Indicator Switch	1653	1653	1	The switch used to identify if a beneficiary is enrolled in a Managed Care Organization.	If any claim that comprises the Stay has has a condition code (CLM RLT COND CD) equal to '04' populate the MEDPAR Informational Encounter Switch with a 'Y'. If no '04' condition code, populate field with an 'N'.	MEDPAR_INFRMTL_ENCTR_IND_TB
MA Teaching Indicator Switch	1654	1654	1	The code used to identify whether the claim contains any request for supplemental IME/DGME/N&AH payment.	If any claim that comprises the Stay has has a condition code (CLM-RLT-COND-CD) equal to '69' populate the MEDPAR MA Teaching Indicator Switch with a 'Y'. If no '69' condition code, populate field with an 'N'.	MEDPAR_MA_TCHNG_IND_TB
Product Replacement within Product Lifecycle Switch	1655	1655	1	The switch used to identify whether a claim involves the replacement of a product earlier than the anticipated lifecycle due to an indication the product is not functioning properly.	If any claim that comprises the Stay has has a condition code (CLM-RLT-COND-CD) equal to '49' populate the MEDPAR Product Replacement within Product Lifecycle Switch with a 'Y'. If no '49' condition code, populate field with an 'N'.	MEDPAR_PROD_RPLCMT_LIFECYC_TB
Product Replacement for known Recall of Product Switch	1656	1656	1	The switch used to identify whether a claim involves the replacement of a product as a result of the Manufacturer or FDA having identified the product for recall and therefore a replacement.	If any claim that comprises the Stay has a Condition code CLM-RLT-COND-CD) equal to '50' populate the MEDPAR Product Replacement Recall Switch with a 'Y'. If no '50' condition code	MEDPAR_PROD_RPLCMT_RCLL_TB
Credit Received from Manufacturer for Replaced Medical Device Switch	1657	1657	1	The switch used to identify whether the provider received a credit from the Manufacturer for a replaced medical device.	If any claim that comprises the Stay has a value code (CLM-VAL-CD) equal to 'FD' populate the MEDPAR Credit Received from Manufacturer for Replaced Medical Device Switch with a 'Y'. If no 'FD' value code, populate field with an 'N'.	MEDPAR_CRED_RCVD_RPLCD_DVC_TB
Observation Switch	1658	1658	1	The switch used to identify whether the claim involves treatment or observation in an observation room.	If any claim that comprises the Stay has a revenue center code (REV-CNTR-CD) equal to '0762' populate the MEDPAR Observation Switch with a 'Y'. If no '0762' revenue center code populate field with an 'N'.	MEDPAR_OBSRVTN_TB
New Technology Add On Amount	1659	1667	9	The amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceeds the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary.	This field is derived by accumulating the amount field (CLM-VAL-AMT) found in the value code trailer for value code (CLM-VAL-CD) equal to '77' for any claim records included in the stay.	
Base Operating DRG Amount	1668	1676	9	The sum of the claim base operating DRG amounts reported on the claims that comprise the stay. The base operating DRG amount used to identify the wage-adjusted DRG operating payment plus the new technology add-on payment.	This field is derived by accumulating the Claim Base Operating DRG amount (CLM-BASE-OPRTG-DRG-AMT) that is present on any of the claim records included in the stay (i.e. the sum of the claim base operating DRG amounts reported on the claims that comprise the stay).	
Operating HSP Amount	1677	1685	9	The sum of the claim operating HSP amounts reported on the claims that comprise the stay. The operating HSP amount is used to identify the difference between the HSP rate payment (updated HSP x DRG weight) and the federal rate payment (includes DSH, IME, outliers, etc. as applicable) when HSP rate payment exceeds Federal rate payment (otherwise $0).	This field is derived by accumulating the Claim Operating HSP Amount (CLM_OPRTG_HSP_AMT) that is present on any of the claim records included in the stay (i.e. the sum of the claim operating HSP amounts reported on the claims that comprise the stay).	
Medical/Surgical General Amount	1686	1694	9	The charge amount (rounded to whole dollars) for the medical/surgical general supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR- TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0270' from all claim records included in the stay.	
Medical/Surgical Non-Sterile Supplies Amount	1695	1703	9	The charge amount (rounded to whole dollars) for the medical/surgical nonsterile supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0271' from all claim records included in the stay.	
Medical/Surgical Sterile Supplies Amount	1704	1712	9	The charge amount (rounded to whole dollars) for the medical/surgical sterile supplies related to the beneficiary's stay.	This field is derived by accumualting the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0272' from all claim records included in the stay.	
Medical/Surgical Take Home Amount	1713	1721	9	The charge amount (rounded to whole dollars) for the medical/surgical take home supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0273' from all claim records included in the stay.	
Medical/Surgical Prosthetic/Orthotic Device Amount	1722	1730	9	The charge amount (rounded to whole dollars) for the medical/surgical prosthetic/orthotic supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0274' from all claim records included in the stay.	
Medical/Surgical Pacemaker Amount	1731	1739	9	The charge amount (rounded to whole dollars) for the medical/surgical pacemaker supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG- AMT) associated with revenue center code (REV- CNTR-CD) '0275' from all claim records included in the stay.	
Medical/Surgical Intraocular Lens Amount	1740	1748	9	The charge amount (rounded to whole dollars) for the medical/surgical intraocular lens supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0276' from all claim records included in the stay.	
Medical/Surgical Oxygen Take Home Amount	1749	1757	9	The charge amount (rounded to whole dollars) for the medical/surgical oxygen take home supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0277' from all claim records included in the stay.	
Medical/Surgical Other Implants Amount	1758	1766	9	The charge amount (rounded to whole dollars) for the medical/surgical other implant supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0278' from all claim records included in the stay	
Medical/Surgical Other Supplies/Devices Amount	1767	1775	9	The charge amount (rounded to whole dollars) for the medical/surgical other devices supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0279' from all claim records included in the stay.	
Medical/Surgical Supplies Incident to Radiology Amount	1776	1784	9	The charge amount (rounded to whole dollars) for the medical/surgical supplies incident to radiology related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0621' from all claim records included in the stay.	
Medical/Surgical Supplies Incident to Other Diagnostic Service Amount	1785	1793	9	The charge amount (rounded to whole dollars) for the medical/surgical supplies incident to other diagnostic services related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0622' from all claim records included in the stay.	
Medical/Surgical Dressings Amount	1794	1802	9	The charge amount (rounded to whole dollars) for the medical/surgical dressing supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV CNTR CD) '0623' from all claim records included in the stay.	
Medical/Surgical Investigational Device Amount	1803	1811	9	The charge amount (rounded to whole dollars) for the medical/surgical investigational devices supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0624' from all claim records included in the stay.	
Medical/Surgical Miscellaneous Amount	1812	1820	9	The charge amount (rounded to whole dollars) for the medical/surgical miscellaneous supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD_ '0620', '0625', '0626', '0627', '0628' & '0629' from all claim records included in the stay.	
Radiology Oncology Amount	1821	1829	9	The charge amount (rounded to whole dollars) for the oncology services/supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0280', '0281', '0282', '0283', '0284', '0285', '0286', '0287', '0288' & '0289' from all claim records included in the stay.	
Radiology Diagnostic Amount	1830	1838	9	The charge amount (rounded to whole dollars) for the radiology diagnositic services related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0320', '0321', '0322','0323', '0324', '0325', '0326', '0327', '0328' & '0329' from all claim records included in the stay.	
Radiology Therapeutic Amount	1839	1847	9	The charge amount (rounded to whole dollars) for the radiology therapeutic services/supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0330', '0331', '0332', '0333', '0334', '0335', '0336', '0337', '0338' & '0339' from all claim records included in the stay.	
Radiology Nuclear Medicine Amount	1848	1856	9	The charge amount (rounded to whole dollars) for the nuclear medicine services/supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0340', '0341', '0342', '0343', '0344', '0345', '0346' '0347', '0348' & '0349' from all claim records included in the stay.	
Radiology Computed Tomographic (CT) Amount	1857	1865	9	The charge amount (rounded to whole dollars) for the Computed Tomographic (CT) services related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0350', '0351', '0352', '0353', '0354', '0355', '0356', '0357', '0358' & '0359' from all claim records records included in the stay.	
Radiology Other Imaging Services Amount	1866	1874	9	The charge amount (rounded to whole dollars) for the radiology other imaging services related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0400', '0401', '0402', '0403', '0404', '0405', '0406', '0407', '0408' & '0409' from all claim records included in the stay.	
Operating Room Amount	1875	1883	9	The charge amount (rounded to whole dollars) for the operating room services/supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR-TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0360', '0361', '0362', '0363', '0364', '0365', '0366', '0367', '0368', '0369', '0710', '0711', '0712', '0713', '0714', '0715', '0717', '0718' & '0719' from all claim records included in the stay.	
Operating Room Labor and Delivery Amount	1884	1892	9	The charge amount (rounded to whole dollars) for the labor room/delivery services/supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR- TOT-CHRG-AMT) associated with revenue center code (REV-CNTR-CD) '0720', '0721', '0722', '0723', '0724', '0725', '0726', '0727', '0728' & '0729' from all claim records included in the stay.	
Cardiac Catheterization Amount	1893	1901	9	The charge amount (rounded to whole dollars) for the cardiac catherization services/supplies related to the beneficiary's stay.	This field is derived by accumulating the revenue center total charge amount (REV-CNTR- TOT-CHRG-AMT) associated with revenue center codes (REV-CNTR-CD) '0481' from all claim records included in the stay.	

Sequestration Reduction Amount	1902	1910	9	This field represents the sequestration reduction amount (rounded to whole dollars).	This field is derived by accumulating the amount field (CLM-VAL-AMT) found in the value code trailer for value code (CLM-VAL-CD) equal to '73' for any claim records included in the stay.	
Uncompensated Care Payment Amount	1911	1919	9	The field represents the uncompensated care amount (rounded to whole dollars) of the payment for DSH hospitals. Uncompensated care payments are effective for claims with discharge dates on or after 10/1/2013. For payment policies, see the Affordable Care Act section 3133 and the FY 2014 IPPS final rule.	This field is derived by accumulating the Claim IPPS Flexible Payment 1 Amount (CLM-IPPS-FLEX-PMT-1-AMT) that is present on any of the claim records included in the stay (i.e. the sum of the claim IPPS flexible payment 1 amounts reported on the claims that comprise the stay).	
Bundled Adjustment Amount	1920	1928	9	This field represents the amount (rounded to whole dollars) the claim was reduced by. This field only applies to providers participating in the CMMI model 1 bundled payment program and the adjustment is calculated off the base operating DRG amount field. See CMMI webpage for details on the Model 1 bundled payment program: http://innovation.cms.gov/initiatives/bundled-payments/	This field is derived by accumulating the Claim IPPS Flexible Payment 2 Amount (CLM-IPPS-FLEX-PMT-2-AMT) that is present on any of the claim records included in the stay (i.e. the sum of the claim IPPS flexible payment 2 amounts reported on the claims that comprise the stay).	
VBP Adjustment Amount	1929	1937	9	This field represents the amount (rounded to whole dollars) of the Hospital Value Based Purchasing (VBP) amount. This could be an additional payment on the claim or a reduction, depending on the hospital's score. For details on the VBP program, see the website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing	This field is derived by accumulating the Claim IPPS Flexible Payment 3 Amount (CLM-IPPS-FLEX-PMT-3-AMT) that is present on any of the claim records included in the stay (i.e. the sum of the claim IPPS flexible payment 3 amounts reported on the claims that comprise the stay).	
HRR Adjustment Amount	1938	1946	9	The amount field (rounded to whole dollars) that represents the Hospital Readmission Reduction (HRR) Program amount. This is a reduction to the claim for readmissions. This field holds a negative amount. For details on the readmission program, see website: http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html	This field is derived by accumulating the Claim IPPS Flexible Payment 4 Amount (CLM-IPPS-FLEX-PMT-4-AMT) that is present on any of the claim records included in the stay (i.e. the sum of the claim IPPS flexible payment 4 amounts reported on the claims that comprise the stay).	
DRG Version 29	1947	1949	3	The DRG version assigned to this stay.		
DRG Version 30	1952	1954	3	The DRG version assigned to this stay.		
DRG Version 31	1957	1959	3	The DRG version assigned to this stay.		
DRG Version 32	1962	1964	3	The DRG version assigned to this stay.		