Expanded Modified Medicare Provider Analysis and Review (MEDPAR) Limited Data Set

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.

1. 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	-	1004
Record Format	-	Fixed
Sort Sequence	-	Medicare Provider Number (Field 12)
Layout Changes	-	DRGs 27 to 30 are included on this file.

Variable Definitions:

1. MEDPAR NCH Claim Type Code

The code used to identify the type of claim record being processed in NCH.

10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Medicare Advantage IME/GME Claims
63 = Medicare Advantage (no-pay) claims
64 = Medicare Advantage (paid as FFS) claims

SOURCE : NCH

2. MEDPAR Beneficiary Age

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

The beneficiary's age as of date of admission.

SOURCE : NCH

3. MEDPAR Beneficiary Sex Code

The sex of a beneficiary.

NOTE: This field comes from the sex code that is present on the first claim record included in the stay.

1 = Male
2 = Female
0 = Unknown

SOURCE : NCH

4. MEDPAR Beneficiary Race Code

The race of a beneficiary.

NOTE: This field comes from the race code that is present on the first claim record included in the stay.

0 = Unknown
1 = White
2 = Black
3 = Other
4 = Asian

5 = Hispanic
6 = North American Native

SOURCE : NCH

5. MEDPAR Beneficiary Medicare Status Code

The reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).

DERIVATIONS :
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. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 AND OVER	N/A
11	YES	N/A	YES	65 AND OVER	N/A
20	NO	YES	NO	UNDER 65	N/A
21	NO	YES	YES	UNDER 65	N/A
31	NO	NO	YES	ANY AGE	T.

SOURCE : NCH

6. MEDPAR Beneficiary Residence SSA Standard State Code

The SSA standard state code of a beneficiary's residence.

NOTE: This field comes from the state code that is present on the first claim record included in the stay.

See the state code table in the tables section of this document.

SOURCE : NCH

7. MEDPAR Admission Day Code

The code indicating the day of the week on which the beneficiary was admitted to a facility.

DERIVATIONS :
This field is derived from the admission date that is present on the first claim record included in the stay.

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

SOURCE : NCH

8. MEDPAR Beneficiary Discharge Status Code

The code used to identify the status of the patient as of

the CLM_THRU_DT.

DERIVATIONS :
This field is derived from the claim status code that is present on the last claim record included in the stay.

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

SOURCE : NCH

9. MEDPAR GHO Paid Code

The code indicating whether or not a GHO has paid the provider for the claim(s).

NOTE: This field comes from the GHO-paid indicator that is present on the first claim record included in the stay.

0 - Not paid by HMO
1 - Paid by HMO

SOURCE : NCH

10. MEDPAR PPS Indicator Code

The code indicating whether or not the facility is being paid under the prospective payment system (PPS).

DERIVATIONS :

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.)

SOURCE : NCH

11. MEDPAR Organization NPI Number

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.

NOTE: EFFECTIVE MAY 23, 2007, THE NPI BECAME THE NATIONAL STANDARD IDENTIFIER FOR COVERED HEALTH CARE PROVIDERS. THE NPI WILL REPLACE CURRENT OSCAR PROVIDER NUMBERS, UPINS, NSC NUMBERS, AND LOCAL CONTRACTOR PROVIDER IDENTIFICATION NUMBERS (PINS) ON STANDARD HIPPA CLAIM TRANSACTIONS.

NOTE1: CMS HAS DETERMINED THAT DUAL PROVIDER IDENTIFIERS (LEGACY NUMBERS AND NEW NPI) MUST BE AVAILABLE IN THE NCH. AFTER THE 5/07 NPI IMPLE-MENTATION, THE STANDARD SYSTEM MAINTAINERS WILL ADD THE LEGACY NUMBER TO THE CLAIM WHEN IT IS ADJUDICATED.

NOTE: THIS FIELD COMES FROM THE ORGANIZATION NPI THAT IS PRESENT ON THE FIRST CLAIM RECORD INCLUDED IN THE STAY.

12. MEDPAR Provider Number

The 6 digit legacy provider number refered to as the CMS Certification Number (CCN).

The first two positions of the provider number, identifies the state of the institutional provider that furnished services to the beneficiary during the stay.

The third position of the provider number, identifies category of institutional provider that furnished services to the beneficiary during the stay.

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.

SOURCE : NCH

13. MEDPAR Provider Number Special Unit Code

The code identifying the special numbering system for units of hospitals that are excluded from PPS or hospitals with SNF swing-bed designation.

DERIVATIONS :
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.

See Provider Number Special Unit Code table in this document.

SOURCE : NCH

14. MEDPAR Short Stay/Long Stay/SNF Indicator Code

The code indicating whether the stay is a short stay, long stay, or SNF.

DERIVATIONS :
This field is derived from the third position of the provider number that is present on the first claim record included in the stay.

See SS/LS/SNF Indicator table in this document.

SOURCE : NCH

15. Number of Bills

The count of the number of claim records (final action) included in the stay.

16. MEDPAR Admission Date

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 year
3YY = Third quarter of year

4YY = Fourth quarter of year

17. MEDPAR Discharge Date

The date on which the beneficiary was discharged or died. 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

18. MEDPAR Length of Stay Day Count

The count in days of the total length of a beneficiary's stay in a hospital or SNF.

DERIVATIONS :
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.'

SOURCE : NCH

19. MEDPAR Outlier Day Count

The count of the number of days paid as outliers (either a day or cost outlier) under PPS beyond the DRG threshold.

DERIVATIONS :
This field is derived by checking the MEDPAR utilization day count against the DRG threshold table (DRG weights file).

SOURCE : MEDPAR

20. MEDPAR Utilization Day Count

The count of the number of covered days of care that are chargeable to Medicare utilization for the stay.

DERIVATIONS :
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).

SOURCE : NCH

21. MEDPAR Beneficiary Total Coinsurance Day Count

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.

DERIVATIONS :
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).

SOURCE : NCH

22. MEDPAR Beneficiary LRD Used Count

The count of the number of lifetime reserve days (LRD) used by the beneficiary for this stay.

DERIVATIONS :
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).

SOURCE : NCH

23. MEDPAR Beneficiary Part A Coinsurance Liability Amount

The amount of money (rounded to whole dollars) identified as the beneficiary's liability for part A coinsurance for the stay.

DERIVATIONS :
This field is derived by accumulating the beneficiary's part a coinsurance liability amount that is present on any of the claim records included in the stay (i.e., the sum of coinsurance amounts reported on the claims that comprise the stay).

SOURCE : NCH

EDIT RULES :

+$$$$$$$

24. MEDPAR Beneficiary Inpatient Deductible Liability Amount

The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the Inpatient deductible for the stay.

DERIVATIONS :
This field is derived by accumulating the beneficiary Inpatient deductible amount that is present on any of the claim records included in the stay (i.e., the sum of the Inpatient deductibles reported on the claims that comprise the stay).

SOURCE : NCH

EDIT RULES :
+$$$$$$$
Rounded; On-size (overflow) Situation = All nines

25. MEDPAR Beneficiary Blood Deductible Liability Amount

The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the blood deductible for the stay.

DERIVATIONS :
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).

SOURCE : NCH

LIMITATIONS :

REFER TO :
MEDPAR_BLOOD_DDCTBL_AMT_LIM

EDIT RULES :
+$$$$$$$
Rounded; On-size (overflow) Situation = All nines

26. MEDPAR Beneficiary Primary Payer Amount

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.

DERIVATIONS :
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).

SOURCE : NCH

EDIT RULES :
+$$$$$$$
Rounded; On-size (overflow) situation = All nines

27. MEDPAR DRG Outlier Approved Payment Amount

The amount of additional payment (rounded to whole dollars)

approved due to an outlier situation over the DRG allowance for the stay.

DERIVATIONS :
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).

COMMENTS :
THIS AMOUNT IS ALREADY INCLUDED IN THE MEDPAR MEDICARE PAYMENT AMOUNT.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

28. MEDPAR Inpatient Disproportionate Share Amount

The amount paid over the DRG amount (rounded to whole dollars) for the disproportionate share hospital for the stay.

DERIVATIONS :
This field is derived by accumulating the value amount associated with value code = 18 that is present on any of the claim records included in the stay (i.e., the sum of value code 18 amounts reported on the claims that comprise the stay).

COMMENTS :
THIS AMOUNT IS ALREADY INCLUDED IN THE MEDPAR MEDICARE PAYMENT AMOUNT.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

29. MEDPAR Indirect Medical Education (IME) Amount

The amount of additional payment (rounded to whole dollars) made to teaching hospitals for IME for the stay.

DERIVATIONS :
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).

COMMENTS :
This amount is already included in the MEDPAR Medicare payment amount.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

30. MEDPAR DRG Price Amount

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).

DERIVATIONS :
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.

SOURCE : NCH

LIMITATIONS :

REFER TO :
MEDPAR_DRG_PRICE_AMT_LIM

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

31. MEDPAR Total Pass Through Amount

The total of all claim pass through amounts (rounded to whole dollars) for the stay.

DERIVATIONS :
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).

COMMENTS :

costs,

Items reimbursed as pass through include capital-related

direct medical education costs, kidney acquisition costs for hospitals approved as rtc's, and bad debts (per provider reimbursement manual, part 1, section 2405.2).

The MEDPAR pass thru amount is not included in the MEDPAR Medicare payment amount.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

32. MEDPAR Total PPS Capital Amount

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).

DERIVATIONS :
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).

COMMENTS :
This field is already included in the MEDPAR Medicare payment amount.

SOURCE : NCH

EDIT RULES :
+$$$$$$$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

33. MEDPAR Total Charge Amount

The total amount (rounded to whole dollars) of all charges (covered and noncovered) for all services provided to the beneficiary for the stay.

DERIVATIONS :
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).

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

34. MEDPAR Total Covered Charge Amount

The portion of the total charges amount (rounded to whole dollars) that is covered by Medicare for the stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

35. MEDPAR Medicare Payment Amount

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.

DERIVATIONS :
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).

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

36. MEDPAR All Accommodations Total Charge Amount

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.

DERIVATIONS :
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).

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

37. MEDPAR Departmental Total Charge Amount

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.

DERIVATIONS :
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).

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

38. MEDPAR Accommodations Days Group

39. MEDPAR Private Room Day Count

The count of the number of private room days used by the beneficiary for the stay.

DERIVATIONS :
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.

SOURCE : NCH

40. MEDPAR Semiprivate Room Day Count

The count of the number of semi-private room days used by the beneficiary for the stay.

DERIVATIONS :
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.

SOURCE : NCH

41. MEDPAR Ward Day Count

The count of the number of ward days used by the beneficiary for the stay.

DERIVATIONS :
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.

SOURCE : NCH

42. MEDPAR Intensive Care Day Count

The count of the number of intensive care days used by the beneficiary for the stay.

DERIVATIONS :
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.

SOURCE : NCH

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'.

43. MEDPAR Coronary Care Day Count

The count of the number of coronary care days used by the beneficiary for the stay.

DERIVATIONS :
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.

SOURCE : NCH

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'.

44. MEDPAR Accommodations Charges Group

45. MEDPAR Private Room Charge Amount

The charge amount (rounded to whole dollars) for private room accommodations related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

46. MEDPAR Semi-Private Room Charge Amount

The charge amount (rounded to whole dollars) for semi-private room accommodations related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

47. MEDPAR Ward Charge Amount

The charge amount (rounded to whole dollars) for ward accommodations related to a beneficiary's stay.

DERIVATIONS :
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 015x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

48. MEDPAR Intensive Care Charge Amount

The charge amount (rounded to whole dollars) for intensive care accommodations related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

49. MEDPAR Coronary Care Charge Amount

The charge amount (rounded to whole dollars) for coronary care accommodations related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

50. MEDPAR Service Charges Group

51. MEDPAR Other Service Charge Amount

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.

DERIVATIONS :
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.)

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

52. MEDPAR Pharmacy Charge Amount

The charge amount (rounded to whole dollars) for pharmaceutical costs related to the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

53. MEDPAR Medical/Surgical Supple Charge Amount

The charge amount (rounded to whole dollars) for medical/surgical supplies related to the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

54. MEDPAR DME Charge Amount

The charge amount (rounded to whole dollars) for DME (purchase of new DME and rentals) related to the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

55. MEDPAR Used DME Charge Amount

The charge amount (rounded to whole dollars) for used DME (purchase of used DME) related to the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

56. MEDPAR Physical Therapy Charge Amount

The charge amount (rounded to whole dollars) for physical therapy services provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

57. MEDPAR Occupational Therapy Charge Amount

The charge amount (rounded to whole dollars) for occupational therapy services provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

58. MEDPAR Speech Pathology Charge Amount

The charge amount (rounded to whole dollars) for speech pathology services (speech, language, audiology) provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

59. MEDPAR Inhalation Therapy Charge Amount

The charge amount (rounded to whole dollars) for inhalation therapy services (respiratory and pulmonary function) provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

60. MEDPAR Blood Charge Amount

The charge amount (rounded to whole dollars) for blood provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

61. MEDPAR Blood Administration Charge Amount

The charge amount (rounded to whole dollars) for blood storage and processing related to the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

62. MEDPAR Operating Room Charge Amount

The charge amount (rounded to whole dollars) for the operating room, recovery room, and labor room delivery used by the beneficiary during the stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

63. MEDPAR Lithotripsy Charge Amount

The charge amount (rounded to whole dollars) for lithotripsy services provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

64. MEDPAR Cardiology Charge Amount

The charge amount (rounded to whole dollars) for cardiology services and electrocardiogram(s) provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

65. MEDPAR Anesthesia Charge Amount

The charge amount (rounded to whole dollars) for anesthesia services provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

66. MEDPAR Laboratory Charge Amount

The charge amount (rounded to whole dollars) for laboratory costs related to the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

67. MEDPAR Radiology Charge Amount

The charge amount (rounded to whole dollars) for radiology costs (including oncology, excluding MRI) related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

68. MEDPAR MRI Charge Amount

The charge amount (rounded to whole dollars) for MRI services provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

69. MEDPAR Outpatient Service Charge Amount

The charge amount (rounded to whole dollars) for outpatient services provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

70. MEDPAR Emergency Room Charge Amount

The charge amount (rounded to whole dollars) for emergency room services provided during the beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

71. MEDPAR Ambulance Charge Amount

The charge amount (rounded to whole dollars) for ambulance services related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :

+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

72. MEDPAR Professional Fees Charge Amount

The charge amount (rounded to whole dollars) for professional fees related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

73. MEDPAR Organ Acquisition Charge Amount

The charge amount (rounded to whole dollars) for organ acquisition or other donor bank services related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
      +$$$$$$$
      ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

74. MEDPAR ESRD Revenue Setting Charge Amount

The charge amount (rounded to whole dollars) for ESRD services (other than organ acquisition and other donor bank) related to a beneficiary's stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
      +$$$$$$$
      ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

75. MEDPAR Clinic Visit Charge Amount

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.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :

+$$$$$$$
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

76. MEDPAR Accommodations/Services Indicator Group

77. MEDPAR Intensive Care Unit (ICU) Indicator Code

The code indicating that the beneficiary has spent time under intensive care during the stay. It also specifies the type of ICU.

DERIVATIONS :
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.

SOURCE : NCH

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'.

CODE TABLE : MEDPAR_ICU_IND_TB

78. MEDPAR Coronary Care Indicator Code

The code indicating that the beneficiary has spent time under coronary care during the stay. It also specifies

the type of coronary care unit.

DERIVATIONS :
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.

SOURCE : NCH

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'.

CODE TABLE : MEDPAR_CRNRY_CARE_IND_TB

79. MEDPAR Pharmacy Indicator Code

The code indicating whether or not the beneficiary received drugs during the stay. It also specifies the type of drugs.

DERIVATIONS :
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.

SOURCE : NCH

CODE TABLE : MEDPAR_PHRMCY_IND_TB

80. MEDPAR Transplant Indicator Code

The code indicating whether or not the beneficiary received a organ transplant during the stay.

DERIVATIONS :
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.

SOURCE : NCH

CODE TABLE : MEDPAR_TRNSPLNT_IND_TB

81. MEDPAR Radiology Indicators Group

82. MEDPAR Radiology Oncology Indicator Switch

1	327	327	NUM

The switch indicating whether or not the beneficiary received radiology oncology services during the stay.

DERIVATIONS :
This field is derived by checking for revenue center code 028X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_RDLGY_ONCLGY_IND_TB

83. MEDPAR Radiology Diagnostic Indicator Switch

The switch indicating whether or not the beneficiary received radiology diagnostic services during the stay.

DERIVATIONS :
This field is derived by checking for revenue center code 032x on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_RDLGY_DGNSTC_IND_TB

84. MEDPAR Radiology Therapeutic Indicator Switch

The switch indicating whether or not the beneficiary received radiology therapeutic services during the stay.

DERIVATIONS :
This field is derived by checking for revenue center code 033X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_RDLGY_THRPTC_IND_TB

85. MEDPAR Radiology Nuclear Medicine Indicator Switch

The switch indicating whether or not the beneficiary received radiology nuclear medicine services during the stay.

DERIVATIONS :
This field is derived by checking for revenue center code 034x on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_RDLGY_NUCLR_MDCN_IND_TB

86. MEDPAR Radiology CT Scan Indicator Switch

The switch indicating whether or not the beneficiary received radiology computed tomographic (CT) scan services during the stay.

DERIVATIONS :
This field is derived by checking for revenue center code 035X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_RDLGY_CT_SCAN_IND_TB

87. MEDPAR Radiology Other Imaging Indicator Switch

The switch indicating whether or not the beneficiary received radiology other imaging services during the stay.

DERIVATIONS :
This field is derived by checking for revenue center code 040X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_RDLGY_OTHR_IMGNG_IND_TB

88. MEDPAR Outpatient Services Indicator Code

The code indicating whether or not the beneficiary has received outpatient services, ambulatory surgical care, or both.

DERIVATIONS :
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.

SOURCE : NCH

CODE TABLE : MEDPAR_OP_SRVC_IND_TB

89. MEDPAR Organ Acquisition Indicator Code

The code indicating the type of organ acquisition received by the beneficiary during the stay.

DERIVATIONS :
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.

SOURCE : NCH

CODE TABLE : MEDPAR_ORGN_ACQSTN_IND_TB

90. MEDPAR ESRD Setting Indicator Code

The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present.

DERIVATIONS :
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.

SOURCE : NCH

CODE TABLE : MEDPAR_ESRD_SETG_IND_TB

OCCURS MIN: 0 OCCURS MAX: 5

91. MEDPAR Present On Admission Diagnosis Code Group

92. MEDPAR Claim Present on Admission Diagnosis Code Count

2 346 347 NUM

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.

SOURCE :

EDIT RULES :
Range: 0 to 25

93. MEDPAR Claim Present on Admission Diagnosis Indicator Code

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.

DB2 ALIAS : UNDEFINED
STANDARD ALIAS : MEDPAR_POA_DGNS_IND_CD

LENGTH : 1

OCCURS MIN: 0 OCCURS MAX: 25

94. MEDPAR Present On Admission Diagnosis E Code Group

95. MEDPAR Claim Present on Admission Diagnosis E Code Count

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.

SOURCE :

EDIT RULES :
Range: 0 to 12

96. MEDPAR Claim Present on Admission Diagnosis E Indicator Code

Effective with Version 'J', the code used to identify the present on admission(POA) indicator code associated with the diagnosis E codes.

OCCURS MIN: 0 OCCURS MAX: 12

97. MEDPAR Diagnosis Code Group

98. MEDPAR Diagnosis Code Count

The count of the number of diagnosis codes included in the stay.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
RANGE: 1 through 25

99. MEDPAR Diagnosis Version Code

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

CODE TABLE : CLM_DGNS_VRSN_TB

100. MEDPAR Diagnosis Code

The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM_DGNS_E_GRP).

OCCURS MIN: 0 OCCURS MAX: 25

101. MEDPAR Diagnosis E Code Count

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.

EDIT RULES :
Range: 0 to 12

102. MEDPAR Diagnosis E Version Code

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have

been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

CODE TABLE : CLM_DGNS_VRSN_TB

103. MEDPAR Diagnosis E Code

Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.

NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.
During the Version 'J' conversion this field was populated throughout history.

SOURCE : CWF

EDIT RULES :
ICD-9-CM

OCCURS MIN: 0 OCCURS MAX: 12

104. MEDPAR Surgical Procedure Indicator Switch

The switch indicating whether or not there were any surgical procedures performed during the beneficiary's stay.

DERIVATIONS :
This field is derived by checking for the presence of procedure codes on the last claim record included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_SRGCL_PRCDR_IND_TB

105. MEDPAR Surgical Procedure Code Count

The count of the number of surgical procedure codes included in the stay.

DERIVATIONS :
This field is derived by counting the procedure codes that are reported on the last claim record included in the stay.

SOURCE : NCH

EDIT RULES :
RANGE: 0 through 25

106. MEDPAR Surgical Procedure Version Code

Effective with Version 'J', the code used to indicate if the surgical procedure code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

CODE TABLE : CLM_PRCDR_VRSN_TB

107. MEDPAR Surgical Procedure Code

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.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DERIVATIONS :
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.

SOURCE : NCH

EDIT RULES :
4 POSITION Surgical Procedure Code LEFT JUSTIFIED

OCCURS MIN: 0 OCCURS MAX: 25

108. MEDPAR Blood Pints Furnished Quantity

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.

DERIVATIONS :
This field is derived by accumulating the blood pints

furnished quantity from all claim records included in the stay.

SOURCE : NCH

109. MEDPAR DRG Code

The code indicating the DRG to which the claims that comprise the stay belong for payment purposes.

DERIVATIONS :
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.

SOURCE : NCH

110. MEDPAR Discharge Destination Code

The code primarily indicating the destination of the beneficiary upon discharge from a facility; also denotes death or SNF/still patient situations.

DERIVATIONS :
This field comes from the claim status code that is present on the last claim record included in the stay.

SOURCE : NCH

CODE TABLE : PTNT_DSCHRG_STUS_TB

111. MEDPAR DRG/Outlier Stay Code

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.

DERIVATIONS :
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

SOURCE : NCH

112. MEDPAR Beneficiary Primary Payer Code

The code indicating the type of payer who has primary responsibility for the payment of the Medicare beneficiary's claims related to the stay.

DERIVATIONS :
This field comes from the primary payer code that is present on the first claim record included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_BENE_PRMRY_PYR_TB

113. MEDPAR ESRD Condition Code

The code indicating if the beneficiary had an ESRD condition reported during the stay.

DERIVATIONS :
This field is derived by checking for condition codes 70 - 76 on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR_ESRD_COND_TB

114. MEDPAR Source Inpatient Admission Code

The code indicating the source of the beneficiary's admission to an Inpatient facility or, for newborn admission, the type of delivery.

DERIVATIONS :
This field comes from the source Inpatient admission code that is present on the last claim record included in the stay.

SOURCE : NCH

CODE TABLE : CLM_SRC_IP_ADMSN_TB

115. MEDPAR Inpatient Admission Type Code

The code indicating the type and priority of the beneficiary's admission to a facility for the Inpatient hospital stay.

DERIVATIONS :
This field comes from the Inpatient admission type code that is present on the last claim record included in the stay.

SOURCE : NCH

116. MEDPAR Fiscal Intermediary/Carrier Identification Number

The identification of the intermediary processing the beneficiary's claims related to the stay.

NOTE: This field comes from the intermediary number that is present on the first claim record included in the stay.

SOURCE : NCH

117. MEDPAR Admitting Diagnosis Version Code

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010 the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

CODE TABLE : CLM_ADMTG_DGNS_VRSN_TB

118. MEDPAR Admitting Diagnosis Code

The ICD code indicating the beneficiary's initial diagnosis at the time of admission.

NOTE: This field comes from the admitting diagnosis code that is present on the last claim record included in the stay.
A diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission.

NOTE1: Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the admitting diagnosis (also known as reason for patient visit) was added to the Outpatient claim. This data was stored in positions 572-576 (FILLER) until the implementation of NCH/NMUD CR#2. Prior to 1/1/2004, this field was only present on inpatient claims.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

NOTE2: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

119. MEDPAR Admission Death Day Count

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).

DERIVATIONS :
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).

SOURCE : NCH/EDB

120. Additional DRG Groupings — The claims are regrouped under the groupers for various years based on the information as it is shown on the claim.

121. DRGV27 — DRG assignment under the FY 2010 Version 27 Grouping Logic.
122. DRGV28 — DRG assignment under the FY 2011 Version 28 Grouping Logic.
123. DRGV29 — DRG assignment under the FY 2012 Version 29 Grouping Logic.
124. DRGV30 — DRG assignment under the FY 2013 Version 30 Grouping Logic.

CLM_ADMTG_DGNS_VRSN_TB — Claim Admitting Diagnosis Version Code Table

Valid Values:
9 = ICD-9
0 = ICD-10

CLM_DGNS_VRSN_TB Claim Diagnosis Version Code Table

Valid Values:
9 = ICD-9
0 = ICD-10

CLM_PRCDR_VRSN_TB Claim Procedure Version Code Table

Valid Values:
9 = ICD-9
0 = ICD-10

CLM_SRC_IP_ADMSN_TB Claim Source Of Inpatient Admission Table

For Inpatient/SNF Claims:

0 = ANOMALY: invalid value, if present, translate to '9'
1 = Non-Health Care Facility Point of Origin (Physician Referral) - The patient was admitted to this facility upon an order of a physician.
2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
3 = HMO referral - Reserved for national

assignment. (eff. 3/08)
Prior to 3/08, HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.

4 = Transfer from hospital (Different Facility) - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.

5 = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) - The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

6 = Transfer from another health care facility - The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.

7 = Emergency room - The patient was admitted to this facility after receiving services in this facility's emergency room department. Obsolete - eff. 7/1/10

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. Includes transfers from incarceration facilities.

9 = Information not available - The means by which the patient was admitted is not known.

A = Reserved for National Assignment. (eff. 3/08)
Prior to 3/08 defined as: 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.(Discontinued July 1,2010- See Condition Code 47)

C = Readmission to Same Home Health Agency - The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1,2010)

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 with out complications. Obsolete eff. 10/1/07

2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. Obsolete eff. 10/1/07

3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status. Obsolete eff. 10/1/07

4 = Extramural birth - A baby delivered in a nonsterile environment. Obsolete eff. 10/1/07

5 = Born Inside this Hospital - eff. 10/1/07

6 = Born Outside of this Hospital - eff. 10/1/07

7-9 = Reserved for national assignment.

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio

37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = California
56 = Canada & Islands
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 = Commonwealth of the Northern Marianas Islands
67 = Texas
68 = Florida (eff. 10/2005)
69 = Florida (eff. 10/2005)
70 = Kansas (eff. 10/2005)
71 = Louisiana (eff. 10/2005)
72 = Ohio (eff. 10/2005)
73 = Pennsylvania (eff. 10/2005)
74 = Texas (eff. 10/2005)

80 = Maryland (eff. 8/2000)
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa;
otherwise unknown

MEDPAR_BENE_PRMRY_PYR_TB MEDPAR Beneficiary Primary Payer Code Table

A = Working aged bene/spouse with eghp
B = ESRD bene in 18-month coordination period with eghp
C = Conditional Medicare payment; future reimbursement expected
D = Auto 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 = Dept of veterans affairs
J = Any liability insurance
Z/BLANK = Medicare is primary payer

MEDPAR_CRNRY_CARE_IND_TB MEDPAR Coronary Care Indicator Code Table

BLANK = No coronary care indication
0 = General (revenue code 0210)
1 = Myocardial (revenue code 0211)
2 = Pulmonary care (revenue code 0212)
3 = Heart transplant (revenue code 0213)
4 = Intermediate CCU (revenue code 0214)

MEDPAR_ESRD_COND_TB MEDPAR ESRD Condition Code Table

00 = No ESRD Condition Codes
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

MEDPAR_ESRD_SETG_IND_TB MEDPAR ESRD Setting Indicator Code Table

00 = Ip renal dialysis-general (revenue code 0800)
01 = Ip renal dialysis-hemodialysis (revenue code 0801)
02 = Ip renal dialysis-peritoneal (non-capd: revenue code 0802)
03 = Ip renal dialysis-capd (revenue code 0803)
04 = Ip renal dialysis-ccpd (revenue code 0804)
09 = Ip renal dialysis-other (revenue code 0809)
20 = Hemodialysis-op-general (revenue code 0820)
21 = Hemodialysis-op-hemodialysis/composite (revenue code 0821)
22 = Hemodialysis-op-home supplies (revenue code 0822)
23 = Hemodialysis-op-home equipment (revenue code 0823)
24 = Hemodialysis-op-maintenance/100% (revenue code 0824)
25 = Hemodialysis-op-support services (revenue code 0825)
29 = Hemodialysis-op-other (revenue code 0829)
30 = Peritoneal-op/home-general (revenue code 0830)
31 = Peritoneal-op/home-peritoneal/composite (revenue
32 = Peritoneal-op/home-home supplies (revenue code 0832)
33 = Peritoneal-op/home-home equipment (revenue code 0833)
34 = Peritoneal-op/home-maintenance/100% (revenue code 0834)
35 = Peritoneal-op/home-support services (revenue code

0835)
39 = Peritoneal-op/home-other (revenue code 0839)
40 = Capd-op-capd/general (revenue code 0840)
41 = Capd-op-capd/composite (revenue code 0841)
42 = Capd-op-home supplies (revenue code 0842)
43 = Capd-op-home equipment (revenue code 0843)
44 = Capd-op-maintenance/100% (revenue code 0844)
45 = Capd-op-support services (revenue code 0845)
49 = Capd-op-other (revenue code 0849)
50 = Ccpd-op-ccpd/general (revenue code 0850)
51 = Ccpd-op-ccpd/composite (revenue code 0851)
52 = Ccpd-op-home supplies (revenue code 0852)
53 = Ccpd-op-home equipment (revenue code 0853)
54 = Ccpd-op-maintenance/100% (revenue code 0854)
55 = Ccpd-op-support services (revenue code 0855)
59 = Ccpd-op-other (revenue code 0859)
80 = Miscellaneous dialysis-general (revenue code 0880)
81 = Miscellaneous dialysis-ultrafiltration (revenue code
0881)
89 = Miscellaneous dialysis-other (revenue code 0889)
BLANK = No ESRD setting indication

MEDPAR_GHO_PD_TB MEDPAR GHO Paid Code Table

1 = GHO has paid the provider
Blank Or 0 = GHO has not paid the provider

MEDPAR_ICU_IND_TB MEDPAR Intensive Care Unit (ICU) Indicator Code

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)

MEDPAR_OP_SRVC_IND_TB MEDPAR Outpatient Services Indicator Cododе Table

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)

MEDPAR_ORGN_ACQSTN_IND_TB MEDPAR Organ Acquisition Indicator Code Table

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 acquisition (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

MEDPAR_PHRMCY_IND_TB MEDPAR Pharmacy Indicator Code Table

0 = No drugs (revenue code other than those listed below)
1 = General drugs and/pr IV therapy (revenue code 025x,

026x)
2 = Erythropoietin (epoetin: revenue code 0630, 0635, 0637, 0639)
3 = Blood clotting drugs (revenue code 0636)
4 = General drugs and/or IV therapy; and epoetin (combination of values 1 and 2)
5 = General drugs and/or IV therapy; and blood clotting drugs (combination of values 1 and 3)

MEDPAR_PPS_IND_TB MEDPAR PPS Indicator Code Table

0 = Non PPS
2 = PPS

MEDPAR_PRVDR_NUM_SPCL_UNIT_TB MEDPAR Provider Number Special Unit Code

M = PPS-exempt psychiatric unit in CAH
R = PPS-exempt rehabilitation unit in CAH
S = PPS-exempt psychiatric unit
T = PPS-exempt rehabilitation unit
U = Swing-bed short-term/acute care hospital
W = Swing-bed long-term hospital
Y = Swing-bed rehabilitation hospital
Z = Swing-bed rural primary care hospital; eff 10/97 changed to critical access hospitals
Blanks = Not PPS-exempt or swing-bed designation

MEDPAR_RDLGY_CT_SCAN_IND_TB MEDPAR Radiology CT Scan Indicator Switch Code Table

0 = No radiology CT scan (revenue code not 035X)
1 = Yes radiology CT scan (revenue code 035X)

MEDPAR_RDLGY_DGNSTC_IND_TB MEDPAR Radiology Diagnostic Indicator Switch Code Table

0 = No radiology-diagnostic (revenue code not 032x)
1 = Yes radiology-diagnostic (revenue code 032x)

MEDPAR_RDLGY_NUCLR_MDCN_IND_TB MEDPAR Radiology Nuclear Medicine Indicator Switch Code Table

0 = No nuclear medicine (revenue code not 034x)
1 = Yes nuclear medicine (revenue code 034x)

MEDPAR_RDLGY_ONCLGY_IND_TB MEDPAR Radiology Oncology Indicator Switch Code Table

0 = No radiology-oncology (revenue code not 028x)
1 = Yes radiology-oncology (revenue code 028x)

MEDPAR_RDLGY_OTHR_IMGNG_IND_TB MEDPAR Radiology Other Imaging Indicator Code Table

0 = No other imaging services (revenue code not 040x)
1 = Yes other imaging services (revenue code 040x)

MEDPAR_RDLGY_THRPTC_IND_TB MEDPAR Radiology Therapeutic Indicator Code Table

0 = No radiology-therapeutic (revenue code not 033X)
1 = Yes radiology-therapeutic (revenue code 033X)

MEDPAR_SRGCL_PRCDR_IND_TB MEDPAR Surgical Procedure Indicator Switch Code Table

0 = No surgery indicated
1 = Yes surgery indicated

MEDPAR_SS_LS_SNF_IND_TB MEDPAR Short Stay/Long Stay/SNF Indicator Code Table

N = SNF Stay (Prvdr3 = 5, 6, U, W, Y, or Z)
S = Short-Stay (Prvdr3 = 0, M, R, S, T)
L = Long-Stay (All Others)

MEDPAR_TRNSPLNT_IND_TB MEDPAR Transplant Indicator Code Table

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)

PTNT_DSCHRG_STUS_TB Patient Discharge Status Table

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) with Medicare
     certification in anticipation of covered

skilled care -- (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 a facility that provides custodial or supportive care (includes intermediate care facilities (ICF). Also used to designate patients that are dischared/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.

05 = Discharged/transferred to a designated cancer center or children's hospital (eff. 10/09). Prior to 10/1/09, discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.

06 = Discharged/transferred to home care of organized home health service organization in anticipation of covered skilled care.

07 = Left against medical advice or discontinued care.

08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)

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

21 = Discharged/transferred to Court/Law Enforcement.

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). Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (certified) providing hospice level of care
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 Medicare certified long term care hospitals. (eff. 1/2002)
64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (eff. 10/2002)
65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).
66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
70 = Discharged/transferred to another type of health care institution not defined elsewhere in code

list.
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)

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