

EXPANDED MODIFIED MEDPAR FILE

UPDATED ON JANUARY 13. 2004



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#### EXPANDED MODIFIED MEDPAR FILE

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

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

Two versions of this file are created each year.

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 nine months after the end of the fiscal year (June file).

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

Record Length	-	550
Blocksize	-	27500
Record Format	-	Fixed
Sort Sequence	-	Medicare Provider Number (Field 13)







EXPANDED MODIFIED MEDPAR

RECORD FORMAT



EXPANDED MODIFIED MEDPAR FILE

FIELD NUMBER	DATA ELEMENT NAME	LOCATION	COBOL PICTURE
1	Filler	1	X(01)
2	Age	2	X(01)
3	Sex	3	X(01)
4	Race	4	X(01)
5	Medicare Status Code (MSC)	5-6	X(02)
6	State	7-8	X(02)
7	City of Residence	9-11	X(03)
8	Filler	12	X(01)
9	Filler	13	X(01)
10	Day of Admission	14	9(01)
11	Discharge Status	15	X(01)
12	HMO Paid Indicator	16	X(01)
13	PPS Indicator	17	X(01)
14	MEDPAR Provider Number	18-23	X(06)
15	Special Unit Character Code	24	X(01)
16	Stay Indicator	25	X(01)
17	Number of Bills	26-28	9(03)
18	Filler	29	X(01)
19	Filler	30	X(01)
20	Filler	31	X(01)

21	Filler	32	X(01)
22	Admission Date	33-35	9(03)
23	Discharge Date	36-38	9(03)
24	Filler	39	X(01)
25	Filler	40	X(01)
26	Filler	41	X(01)
27	Filler	42	X(01)
28	Length of Stay	43-47	9(05)
29	Outlier Days	48-50	9(03)
30	Covered Days	51-53	9(03)
31	Coinsurance Days	54-56	9(03)
32	Lifetime Reserve Days	57-59	9(03)
33	Filler	60	X(01)
34	Filler	61	X(01)
35	Filler	62	X(01)
36	Coinsurance Amount	63-69	9(07)
37	Inpatient Deductible	70-76	9(07)
38	Blood Deductible	77-83	9(07)
39	Primary Payer Amount	84-90	9(07)
40	Outlier Amount	91-97	9(07)
41	Disproportionate Share Amt	98-104	9(07)
42	Indirect Med Education Amt	105-111	9(07)
43	DRG Price	112-118	9(07)
44	Bill Total Per Diem	119-125	9(07)
45	PPS Capital Total Amount	126-132	9(07)
46	Filler	133	X(01)
47	Filler	134	X(01)
48	Filler	135-141	X(07)



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FIELD NUMBER	DATA ELEMENT NAME	LOCATION	COBOL PICTURE
49	Total Charges	142-148	9(07)
50	Covered Charges	149-155	9(07)
51	Reimbursement Amount	156-162	9(07)
52	Total Accommodations Charges	163-169	9(07)
53	Total Departmental Charges	170-176	9(07)
54	Accommodation Days	177-191	9(03)
	Occurs 5 times		
55	Accommodation Charges	192-226	9(07)
	Occurs 5 times		
56	Service Charges	227-401	9(07)
	Occurs 25 times		
57	Intensive Care Indicator	402	X(01)
58	Coronary Care Indicator	403	X(01)
59	Pharmacy Indicator	404	9(01)
60	Transplant Indicator	405	9(01)
61	Radiology Indicator	406-411	9(01)
	Occurs 6 times		
62	Outpatient Services Indicator	412	9(01)
63	Organ Indicator	413-414	X(02)
64	ESRD Setting Indicator	415-424	X(02)
	Occurs 5 times		
65	Number of Diagnosis Codes	425-426	9(02)
66	Diagnostic Codes	427-471	X(05)
	Occurs 9 times		
67	Surgery Indicator	472	X(01)
68	Number of Surgical Codes	473-474	9(02)
69	Filler	475	X(01)
70	Surgical Codes	476-499	X(04)
	Occurs 6 times		
71	Filler	500	X(01)
72	Blood Furnished	501-503	9(03)
73	Filler	504	X(01)
74	DRG Code	505-507	9(03)
75	Discharge Destination	508-509	9(02)
76	Outlier Code/DRG Source	510	9(01)
77	Primary Payer Code	511	X(01)
78	MEDPAR ESRD Condition	512-513	9(02)
79	Source of Admission	514	X(01)
80	Type of Admission	515	X(01)

81	Intermediary Number	516-520	X(05)
82	Admission Diagnosis Code	521-525	X(05)
83	Filler	526	X(01)
84	Filler	527	X(01)
85	Admission To Death Interval	528-532	9(05)
86	Current DRG	533-535	9(03)
87	Proposed/Final DRG	536-538	9(03)
88	Filler	539-550	X(12)





EXPANDED MODIFIED MEDPAR

RECORD DATA DESCRIPTIONS



01 FILLER

(FOR FUTURE USE)

02 AGE

Description:

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

Coding Scheme:

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

1 = less than 25

2 = 25 - 44

3 = 45 - 64

4 = 65 - 69

5 = 70 - 74

6 = 75 - 79

7 = 80 - 84

8 = 85 - 89

9 = 90 and over

Original Source:

SSA and RRB Beneficiary Record Systems

03 SEX

Description:

This field specifies the sex of the beneficiary.

Coding Scheme:

- 0 - Unknown\*
- 1 - Male
- 2 - Female

Original Source:

SSA and RRB Beneficiary Record Systems

Limitations:

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

04 RACE

Description:

This field specifies the beneficiary's race.

Coding Scheme:

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

Original Source:

SSA and RRB Beneficiary Record Systems

Limitations:

Unknown

05 MEDICARE STATUS CODE (MSC)

Description:

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

Coding Scheme:

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



21 - Disabled with ESRD  
31 - ESRD only

Original Source:

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

Limitations:

Unknown

06 STATE

Description:

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

Coding Scheme:

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

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

Original Source:

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

Limitations:

Invalid or unknown states are coded "99."

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

The last three positions in this field contain blanks.

07 FILLER

(FOR FUTURE USE)

08 FILLER

(FOR FUTURE USE)

09 Filler

(FOR FUTURE USE)

10 DAY OF ADMISSION

Description:

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

Coding Scheme:

- 1 - Sunday
- 2 - Monday
- 3 - Tuesday
- 4 - Wednesday

- 5 - Thursday
- 6 - Friday
- 7 - Saturday

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

11 DISCHARGE STATUS

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

12 HMO/PAID INDICATOR

Description:

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

Coding Scheme:

- 0 - Not paid by HMO
- 1 - Paid by HMO

Original Source:

Coded at the Central Office

Limitations:

Unknown



13 PPS Indicator

Description:

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

Coding Scheme:

Code 0 = Not PPS  
2 = PPS

Original Source:

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

field indicates that this is a PPS provider.

Limitations:

Experience with the indicator shows that it was unreliable in 1983, 1984, and 1985.

14 MEDICARE PROVIDER NUMBER

Description:

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

Coding Scheme:

SSTPPP where:

SS = State of the provider (SSA standard State Codes) -  
See Attachment C.

T = Type of provider

PPP = Provider sequence number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

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

15 SPECIAL UNIT CHARACTER CODE

Description:

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

Coding Scheme:

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

Original Source:

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

Limitations:

Effective with provider cost reporting periods beginning on or after October 1, 1987, the Alcohol/Drug units are no longer PPS-exempt units.

16 STAY INDICATOR

Description:

This field specifies the type of stay.

Coding Scheme:

- S - Short stay
- L - Long stay
- N - SNF

Original Source:

Derived from Uniform Bill, Form HCFA-1450

Limitations:

Unknown

17 NUMBER OF BILLS

Description:

This field specifies the number of bills for a stay.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Generated from the stay record at Central Office

Limitations:

Unknown

18 FILLER

(FOR FUTURE USE)



19 FILLER

(FOR FUTURE USE)



(FOR FUTURE USE)

21 FILLER

(FOR FUTURE USE)

22    ADMISSION DATE

Description:

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

Coding Scheme:

QYY where:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

23 DISCHARGE DATE

Description:

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

Coding Scheme:

QYY where:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

24 FILLER

(FOR FUTURE USE)



25 FILLER

(FOR FUTURE USE)



(FOR FUTURE USE)

27 FILLER

(FOR FUTURE USE)

28 LENGTH OF STAY

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

29 OUTLIER DAYS

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

Coding Scheme:

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

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

30 COVERED DAYS

Description:

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

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown



31 COINSURANCE DAYS

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

32 LIFETIME RESERVE DAYS

Description:

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

Coding Scheme:

Three-position field nm, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

33 FILLER

(FOR FUTURE USE)

34 FILLER

(FOR FUTURE USE)

35 FILLER

(FOR FUTURE USE)



36 COINSURANCE AMOUNT

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown



37 INPATIENT DEDUCTIBLE

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

38 BLOOD DEDUCTIBLE

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown



39 PRIMARY PAYER AMOUNT

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

40 OUTLIER AMOUNT

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown

41 DISPROPORTIONATE SHARE

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown

42 MEDPAR IME Amount

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown



43 DRG PRICE

Description:

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

Coding Scheme:

Charges are rounded to whole dollars

Original source:

Computed by the Fiscal Intermediary for all discharges

Limitations:

Unknown

44 BILL TOTAL PER DIEM

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

45 CAPITAL TOTAL AMOUNT

Description:

This field specifies the total reimbursement for depreciation, rent, certain interest, and real estate taxes for hospital

buildings and equipment subject to the PPS, effective with hospital cost reporting periods on or after October, 1991. This amount is included in the Reimbursement Amount.

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

From the Fiscal Intermediary - PPS PRICER Program

Limitations:

Unknown

46 FILLER

(FOR FUTURE USE)

47 FILLER

(FOR FUTURE USE)

48 FILLER

(FOR FUTURE USE)

49 TOTAL CHARGES

Description:

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



Coding Scheme:

Total is rounded to whole dollars

Original Source:

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

Limitations:

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

50 COVERED CHARGES

Description:

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

Coding Scheme:

Proportional amount is rounded to whole dollars

Original Source:

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

Limitations:

Unknown

51 REIMBURSEMENT AMOUNT

Description:

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

Coding Scheme:

Amount is rounded to whole dollars

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

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

52 TOTAL ACCOMMODATIONS CHARGES

Description

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

Coding Scheme:

Total is rounded to whole dollars

Original Source:

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

Limitations:

Unknown

53 TOTAL DEPARTMENTAL CHARGES

Description:

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

Coding Scheme:

Total is rounded to whole dollars

Original Source:

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

Limitations:

Unknown

54 ACCOMMODATION DAYS

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

55 ACCOMMODATION CHARGES

Description:

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

Coding Scheme:

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

Original Source:



Uniform Bill, Form HCFA-1450

Limitations:

Unknown

56 SERVICE CHARGES

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

57 INTENSIVE CARE INDICATOR

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

58 CORONARY CARE INDICATOR

Description:

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

Coding Scheme:

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

9 - Other coronary care (Revenue Code 0219)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

59 PHARMACY INDICATOR

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

1

60 TRANSPLANT INDICATOR

Description:

This field specifies whether the beneficiary has had a transplant.

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

61 RADIOLOGY INDICATORS

Description:

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

Coding Scheme:

Occurs six times

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

- 1st position - Radiology-Oncology (Revenue Code 028X)
- 2nd position - Radiology-diagnostic (Revenue Code 032X)
- 3rd position - Radiology-therapeutic (Revenue Code 033X)



4th position - Radiology-Nuclear medicine (Revenue Code  
034X)  
5th position - Radiology CT scan (Revenue Code 035X)  
6th position - Radiology Other imaging services (Revenue  
Code 040X)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

62 OUTPATIENT SERVICES INDICATOR

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

63 ORGAN INDICATOR

Description:

This field specifies the type of organ transplant.

Coding Scheme:

K1 - General classification (Revenue Code 0810)  
K2 - Living donor kidney (Revenue Code 0811)  
K3 - Cadaver donor kidney (Revenue Code 0812)  
K4 - Unknown donor kidney (Revenue Code 0813)  
K5 - Other kidney acquisition (Revenue Code 0814)  
H1 - Cadaver donor heart (Revenue Code 0815)  
H2 - Other heart acquisition (Revenue Code 0816)  
L1 - Donor liver (Revenue Code 0817)  
O1 - Other organ acquisition (Revenue Code 0819)  
O2 - General classification Revenue Code 0890)  
B1 - Bone donor bank (Revenue Code 0891)  
O3 - Organ donor bank other than kidney (Revenue code 0892)  
S1 - Skin donor bank (Revenue Code 0893)  
O4 - Other donor bank (Revenue Code 0899)  
Blank - no organ acquisition indication

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

64 ESRD SETTING

Description:

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

Coding Scheme:

Inpatient Renal Dialysis

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

Hemodialysis-Outpatient

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

Peritoneal Dialysis-Outpatient/Home

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

CAPD Outpatient

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

64 ESRD SETTING (continued)

CCPD Outpatient

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

Miscellaneous Dialysis

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

65 NUMBER OF Diagnosis CODES

Description:

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

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations

Unknown

66 DIAGNOSIS CODE

Description:

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

Coding Scheme:

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



left justified.

Original Source:

Uniform Bill, Form HCFA-1450

Limitations

May contain invalid codes

67 SURGERY INDICATOR

Description:

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

Coding Scheme:

- 0 - No surgery indicated
- 1 - Yes surgery indicated

Original Source:

This field is derived at the Central Office.

Limitations:

Unknown

68 NUMBER OF SURGICAL CODES

Description:

This field specifies the number of surgical codes reported.

Coding Scheme:

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

69 FILLER

(FOR FUTURE USE)

70 SURGICAL CODE

Description:

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

Coding Scheme:

Occur 6 times

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

71 FILLER

(FOR FUTURE USE)

72 BLOOD FURNISHED

Description:

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

Coding Scheme:

Three-position field nn, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

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



reported with tenths of units).

(FOR FUTURE USE)

74 DRG CODE

Description:

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

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

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

The GROUPER software is updated periodically and total DRG codes vary per version as shown below:

GROUPER	DRG codes
Version 2.0 - from 1/1/83 through 4/30/86	477
Version 3.0 - from 5/1/86 through 9/30/86	477
Version 4.0 - from 10/1/86 through 9/30/87	477
Version 5.0 - from 10/1/87 through 9/30/88	477
Version 6.0 - from 10/1/88 through 9/30/89	477
Version 7.0 - from 10/1/89 through 9/30/90	480
Version 8.0 - from 10/1/90 through 9/30/91	490
Version 9.0 - from 10/1/91 through 9/30/92	492
Version 10.0 - from 10/1/92 through 9/30/93	492
Version 11.0 - from 10/1/93 through 9/30/94	494
Version 12.0 - from 10/1/94 through 9/30/95	495
Version 13.0 - from 10/1/95 through 9/30/96	495
Version 14.0 - from 10/1/96 through 9/30/97	495

Limitations:

DRG 467 and DRG 470 are categories that could not be accurately

classified into valid DRG's.

#### 75 DISCHARGE DESTINATION

##### Description:

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

##### Coding Scheme:

- 01 - Discharged to home/self care (routine charge).
- 02 - Discharged/transferred to other short term general hospital for inpatient care.
- 03 - Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing-bed arrangement, use Code 61 - swing-bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF).
- 04 - Discharged/transferred to intermediate care facility (ICF).
- 05 - Discharged/transferred to another type of institution for inpatient care (including distinct parts).
- 06 - Discharged/transferred to home care of organized home health service organization.
- 07 - Left against medical advice or discontinued care.
- 08 - Discharged/transferred to home under care of a home IV drug therapy provider.

- 09 - Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
- 20 - Expired (did not recover -(Christian Science patient).
- 30 - Still patient.
- 40 - Expired at home (hospice claims only).
- 41 - Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
- 42 - Expired - place unknown (Hospice claims only)
- 50 - Hospice - home (eff. 10/96)
- 51 - Hospice - medical facility (eff. 10/96)
- 61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
- 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
- 63 - Discharged/transferred to a long term care hospital. (eff. 1/2002)
- 64 - Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.(eff. 10/2002)
- 71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care. (eff. 9/2001)
- 72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care.(eff. 9/2001)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

76 OUTLIER CODE/DRG SOURCE

Description:

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

Coding Scheme:

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

Codes applicable to PPS Providers:

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

Codes applicable to non-PPS Providers:

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

Original Source:

This field is coded at the Central Office.

Limitations:

Unknown

77 PRIMARY PAYER CODE

Description:

This field specifies the payer of this claim.

Coding Scheme:

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

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown



78 MEDPAR ESRD CONDITION CODE

Description

This field specifies the ESRD condition codes found on the beneficiary's bill. (medpar\_ESRD\_cond\_c)

Coding Scheme:

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

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

79 SOURCE OF ADMISSION

Description:

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

Coding Scheme:

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

The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.

- 7 - Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.
- 8 - Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
- 9 - Information not available - The means by which the patient was admitted is not known.
- A - Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

**\*\*For Newborn Type of Admission\*\***

- 1 - Normal delivery - A baby delivered without complications.
- 2 - Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status.
- 3 - Sick baby - A baby delivered with medical complications, other than those relating to premature status.
- 4 - Extramural birth - A baby delivered in a nonsterile environment.
- 5-8 Reserved for national assignment.
- 9 - Information not available.

Original Source:

Uniform Bill, Form HCFA-1450

Limitations: Unknown

80 TYPE OF ADMISSION

Description:

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

Coding Scheme:

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

STANDARD ALIAS: CLM\_IP\_ADMSN\_TYPE\_CD

SQL ALIAS: IP\_ADMSN\_TYPE\_CD

SAS ALIAS: TYPE\_ADM

TITLE ALIAS: IP\_ADMISSION\_TYPE

CODES:

0 - Blank

1 - Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.

2 - Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.

3 - Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations.

4 - Newborn - Necessitates the use of special source of admission codes.

5-8 Reserved.

9 - Unknown - Information not available.

Original Source:

Xeroxed from NCH

Limitations:

Unknown

81 INTERMEDIARY NUMBER

Description:

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

Coding Scheme:

For the first two positions:

- 00 - Blue Cross
  - nn - Commercial Plan
- 
- 00010 - Alabama BC - Alabama
  - 00011 - Alabama BC - Iowa
  - 00020 - Arkansas BC
  - 00030 - Arizona BC
  - 00040 - California BC (term. 12/00)
  - 00050 - New Mexico BC/CO (term. 06/89)
  - 00060 - Connecticut BC (term. 06/99)
  - 00070 - Delaware BC -(term.02/98)
  - 00080 - Florida BC -(term. 03/88)
  - 00090 - Florida BC
  - 00101 - Georgia BC
  - 00121 - Illinois - HCSC (term. 08/98)
  - 00123 - Michigan - HCSC (term. 08/98)
  - 00130 - Indiana BC/Administar Federal
  - 00131 - Illinois - Administar
  - 00140 - Iowa - Wellmark (term. 6/2000)
  - 00150 - Kansas BC
  - 00160 - Kentucky/Administar
  - 00180 - Maine BC
  - 00181 - Maine BC - Massachusetts
  - 00190 - Maryland BC
  - 00200 - Massachusetts BC (term. 07/97)
  - 00210 - Michigan BC (term. 09/94)
  - 00220 - Minnesota BC (term. 07/99)
  - 00230 - Mississippi BC
  - 00231 - Mississippi BC/LA (term. 09/92)
  - 00232 - Mississippi BC
  - 00241 - Missouri BC (term. 09/92)
  - 00250 - Montana BC
  - 00260 - Nebraska BC
  - 00270 - New Hampshire/VT BC
  - 00280 - New Jersey BC (term. 08/00)
  - 00290 - New Mexico BC - (term. 11/95)
  - 00308 - New York - Empire BC
  - 00310 - North Carolina BC (term. 01/02)
  - 00320 - North Dakota BC
  - 00332 - Community Mutual Ins Co; Ohio Administar

00340 - Oklahoma BC  
00350 - Oregon BC  
00351 - Oregon BC/ID (term. 09/88)  
00355 - Oregon - CWF  
00362 - Independence BC - (term. 08/97)  
00363 - Pennsylvania - Veritus  
00370 - Rhode Island BC  
00380 - South Carolina BC  
00390 - Tennessee BC  
00400 - Texas BC  
00410 - Utah BC (term. 09/00)  
00423 - Virginia BC; Trigon (term. 08/99)  
00430 - Washington/Alaska BC  
00450 - Wisconsin BC - Wisconsin  
00452 - Wisconsin BC - Michigan  
00453 - Wisconsin BC - Virginia & West Virginia  
00454 - Wisconsin BC - California  
00460 - Wyoming BC  
00468 - N Carolina BC/CPRTIVA  
00993 - BC/BS Assoc.  
17120 - Hawaii Medical Service (term. 06/99)  
50333 - Travelers; Connecticut United Healthcare  
(term. - date unknown)  
51051 - Aetna California - (term. 06/97)  
51070 - Aetna Connecticut - (term. 06/97)  
51100 - Aetna Florida - (term. 06/97)  
51140 - Aetna Illinois - (term. 06/97)  
51390 - Aetna Pennsylvania - (term. 06/97)  
52280 - NE - Mutual of Omaha  
57400 - Puerto Rico - Cooperativa  
61000 - Aetna (term. 06/97)  
80883 - Contractor ID for Inpatient & Outpatient  
Risk Adjustment Data (data not sent through  
CWF; but through Palmetto)

Original Source:

From the Fiscal Intermediary

Limitations:

Unknown

82    ADMISSION DIAGNOSIS

Description:

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

Coding Scheme:

Five-position field nnnnn, where n is a number

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown





(FOR FUTURE USE)

84 FILLER

(FOR FUTURE USE)

85    ADMISSION TO Death Interval

Description:

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

Coding Scheme:

Five-position field nnn, where n is a number

Original Source:

MEDPAR

Limitations:

Unknown

86 CURRENT DRG

Description:

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

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

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

Limitations:

DRG 467 and DRG 470 are categories that could not be accurately classified into valid DRG's.

87 PROPOSED DRG

Description:

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

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

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

Limitations:

DRG 467 and DRG 470 are categories that could not be accurately classified into valid DRG's.

88 FILLER

(FOR FUTURE USE)





ATTACHMENTS



Attachment A

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

- Step 1    Compute Age-of-Person
- Step 2    If Age > 64, enter 10 at Medicare Status Code and go to Step 4.
- Step 3    Generate a Medicare Status Code using the original reason for entitlement code (OREC) and the current reason for entitlement code (CREC) and the following table:

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

- Step 4    If Medicare Status Code = 10 or 20 AND  
End Stage Renal Disease Indicator (ESRDI) = A thru G,

add 1 to Medicare Status Code (generate 11 or 21 codes).

Note:

Reason for Entitlement:

- 0 - OASI
- 1 - DIB
- 2 - Renal
- 3 - DIB & Renal

Medicare Status Code:

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

End Stage Renal Disease Indicator:

- 0 - No ESRD
- A - MBR
- B - HI
- C - NIH
- D - MBR & HI
- E - MBR & HI
- F - HI & NIH
- G - MBR, HI, & NIH
- H - OAS Clerical
- I - MBR/OAS Clerical
- J - HI/OAS Clerical
- K - NIH/OAS Clerical
- L - MBR/HI/OAS Clerical
- M - MBR/NIH/OAS Clerical
- N - HI/NIH/OAS Clerical
- P - MBR/HI/NIH/OAS Clerical



Attachment B  
(Page 1)

Provider Number Coding

- The first two positions are the State code (See Attachment C).
- Position three, and sometimes position four, are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated:

0001-0879 Short-term (General and Specialty) Hospitals  
(where TOB = 11X; ESRD clinic where TOB = 72X)

0880-0899 Reserved for hospitals participating in ORD  
demonstration projects where TOB = 11X;  
ESRD clinic where TOB = 72X

0900-0999 Multiple Hospital Component in a Medical Complex  
(Numbers Retired) where TOB = 11X; ESRD clinic  
where TOB = 72X

1000-1199 Reserved for Future Use

1200-1224 Alcohol/Drug Hospitals (Excluded from PPS -  
Numbers Retired) where TOB = 11X; ESRD clinic  
where TOB = 72X

1225-1299 Medical Assistance Facilities (MONTANA Project)  
ESRD clinic where TOB = 72X

1300-1399 Rural Primary Care Hospital (RPCH) eff. 10/97  
changed to Critical Access Hospitals (CAH)

1400-1499 Continuation of 4600-4799 series (CMHC)

1500-1799 Hospices

1800-1989 Federally Qualified Health Centers (FQHC)  
where TOB = 73X; SNF (IP P7B) where TOB = 22X;  
HHA where TOB = 32X, 33X, 34X eff. 7/00  
changed to Religious Non Medical Health  
Care Institution (RNHCI)

1990-1999 Christian Science Sanatoria (Hospital Services)

2000-2299 Long-Term Hospitals (Excluded from PPS)

2300-2499 Chronic Renal Disease Facilities (Hospital Based)

2500-2899 Non-Hospital Renal Disease Treatment Centers

2900-2999 Independent Special Purpose Renal Dialysis Facility (1)

3000-3024 Formerly Tuberculosis Hospitals (Numbers Retired)

3025-3099 Rehabilitation Hospitals (Excluded from PPS)

3100-3199 Continuation 7300-7399 (HHA) (3)  
(eff. 4/96)

3200-3299 Continuation of 4800-4899 series (CORF)

3300-3399 Children's Hospitals (Excluded from PPS)

3400-3499 Continuation of Rural Health Clinics  
(provider based) (3775-3999)

3500-3699 Renal Disease Treatment Centers (Hospital Satellites)

3700-3799 Hospital Based Special Purpose Renal Dialysis Facility (1)

3800-3974 Rural Health Clinics (Free-Standing)

3975-3999 Rural Health Clinics (Provider Based)

4000-4499 Psychiatric Hospitals (Excluded from PPS)

4500-4599 Comprehensive Outpatient Rehabilitation Facilities  
(CORF)

4600-4799 Community Mental Health Centers (CMHC);  
9/30/91-3/31/97 used for clinic OPT  
where TOB = 74\*

4800-4899 Continuation of 4500-4599 series (CORF)

4900-4999 Continuation of 4600-4799 series(CMHC)  
9/30/91-3/31/97 used for clinic OPT

5000-6499 Skilled Nursing Facilities  
CMHC/outpatient physical etc.

6500-6989 Outpatient Physical Therapy Services

6990-6999 Christian Science Sanatoria (Skilled Nursing Services)  
eff. 7/00 Numbers Reserved (formerly CS)

7000-7299 Home Health Agencies (HHA) (2)

7300-7399 Subunits of "Nonprofit" and "Proprietary" Home Health  
Agencies (3)

7400-7799 Continuation of 7000-7299 Series





Attachment B  
(Page 2)

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

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

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

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

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

Exception:

P001-P999 Organ procurement organization

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

(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45) have been used in reducing acute care costs (RACC) experiments.

(3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.

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

Note:

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

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

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

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

SOURCE:

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

LIMITATIONS:

THE MEDPAR FILE CONTAINS ONLY INPATIENT HOSPITAL RECORDS. PROVIDER NUMBERS ARE VALIDATED AGAINST A FILE OF MEDICARE-CERTIFIED PROVIDERS BY THE INTERMEDIARY. HOWEVER, THIS PROCESS IS NOT REPEATED WHEN THE MEDPAR FILE IS CONSTRUCTED.

## Attachment C

## STATE CODES

01	Alabama	47	Vermont
02	Alaska	48	Virgin Islands
03	Arizona	49	Virginia
04	Arkansas	50	Washington
05,	California	51	West Virginia
06	Colorado	52	Wisconsin
07	Connecticut	53	Wyoming
08	Delaware	54	Africa
09	District of Columbia	56	Canada
10	Florida	57	Central America and West Indies
11	Georgia		
12	Hawaii	58	Europe
13	Idaho	59	Mexico
14	Illinois	60	Oceania
15	Indiana	61	Philippines
16	Iowa	62	South America
17	Kansas	63	U.S. Possessions
18	Kentucky		
19	Louisiana	64**	American Samoa
20	Maine	65**	Guam
21	Maryland	66**	Saipan or Northern Mariana= 94 Army Post Office (APO AE) 95 Army Post Office (APO AA) 96 Army Post Office (APO AP)
22	Massachusetts	97**	Northern Marianas
23	Michigan		
24	Minnesota	98**	Guam
25	Mississippi	99**	American Samoa (with 000 county code; otherwise unknown)
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

\*\* Pacific Territories

Attachment D

OCCURRENCES IN ACCOMMODATION DAYS:

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

OCCURRENCES IN ACCOMMODATION CHARGES:

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

Attachment F

OCCURRENCES IN SERVICE CHARGES:

- 1st Occurrence (227-233) is Other.  
Revenue Center 002 through 099, 22X, 23X, 24X, 52X, 53X,  
55X, 56X, 57X, 58X, 59X, 60X, 64X, 65X, 66X, 67X, 68X, 69X,  
70X, 76X, 77X, 78X, 90X, 91X, 92X, 93X, 94X, 95X, 99X.
- 2nd Occurrence (234-240) is Pharmacy.  
Revenue Center 25X, 26X, 63X.
- 3rd Occurrence (241-247) is Medical/Surgical Supplies.  
Revenue Center 27X, 62X.
- 4th Occurrence (248-254) is Durable Medical Equipment.  
Revenue Center 290, 291, 292.
- 5th Occurrence (255-261) is Used Durable Medical Equipment.  
Revenue Center 293.
- 6th Occurrence (262-268) is Physical Therapy.  
Revenue Center 42X.
- 7th Occurrence (269-275) is Occupational Therapy.  
Revenue Center 43X.
- 8th Occurrence (276-282) is Speech Pathology.  
Revenue Center 44X, 47X.
- 9th Occurrence (283-289) is Inhalation Therapy.  
Revenue Center 41X, 46X.
- 10th Occurrence (290-296) is Blood.  
Revenue Center 38X.
- 11th Occurrence (297-303) is Blood Administration.



Revenue Center 39X.

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

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

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

- 15th Occurrence (325-331) is Anesthesia.  
Revenue Center 37X.
- 16th Occurrence (332-338) is Laboratory.  
Revenue Center 30X, 31X, 74X, 75X.
- 17th Occurrence (339-345) is Radiology.  
Revenue Center 28X, 32X, 33X, 34X, 35X, 40X.
- 18th Occurrence (346-352) is MRI.  
Revenue Center 61X.
- 19th Occurrence (353-359) is Outpatient Services.  
Revenue Center 49X, 50X.
- 20th Occurrence (360-366) is Emergency Room.  
Revenue Center 45X.
- 21st Occurrence (367-373) is Ambulance.  
Revenue Center 54X.
- 22nd Occurrence (374-380) is Professional Fees.  
Revenue Center 96X, 97X, 98X.
- 23rd Occurrence (381-387) is Organ Acquisition.  
Revenue Center 81X, 89X.
- 24th Occurrence (388-394) is ESRD Revenue Setting.  
Revenue Center 80X, 82X, 83X, 84X, 85X, 86X, 87X, 88X.
- 25th Occurrence (395-401) is Clinic Visit.  
Revenue Center 51X.

