EXPANDED MODIFIED MEDPAR FILE

UPDATED MARCH 2008

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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 six months after the end of
the fiscal year (March file).

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

        Record Length -   562
        Blocksize   -   27538
        Record Format -   Fixed
        Sort Sequence -   Medicare Provider Number (Field 13)
        Layout Changes -   Expansion of Covered Days to 9(5)
                            Addition of NPI at end of record

EXPANDED MODIFIED MEDPAR

RECORD FORMAT

```
                    EXPANDED MODIFIED MEDPAR FILE

FIELD                                                  COBOL
NUMBER     DATA ELEMENT NAME            LOCATION        PICTURE

  1        Filler                       1              X(01)
  2        Age                          2              X(01)
  3        Sex                          3              X(01)
  4        Race                         4              X(01)
  5        Medicare Status Code (MSC)   5-6            X(02)
  6        State                        7-8            X(02)
  7        Filler                       9-11           X(03)
  8        Filler                       12             X(01)
  9        Filler                       13             X(01)
 10        Day of Admission             14             9(01)
 11        Discharge Status             15             X(01)
 12        HMO Paid Indicator           16             X(01)
 13        PPS Indicator                17             X(01)
 14        MEDPAR Provider Number       18-23          X(06)
 15        Special Unit Character Code  24             X(01)
 16        Stay Indicator               25             X(01)
 17        Number of Bills              26-28          9(03)
 18        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	51-55	9(05)
31	Coinsurance Days	56-58	9(03)
32	Lifetime Reserve Days	59-61	9(03)
33	Filler	62	X(01)
34	Filler	63	X(01)
35	Filler	64	X(01)
36	Coinsurance Amount	65-71	9(07)
37	Inpatient Deductible	72-78	9(07)
38	Blood Deductible	79-85	9(07)
39	Primary Payer Amount	86-92	9(07)
40	Outlier Amount	93-99	9(07)
41	Disproportionate Share Amt	100-106	9(07)
42	Indirect Med Education Amt	107-113	9(07)
43	DRG Price	114-120	9(07)
44	Bill Total Per Diem	121-127	9(07)
45	PPS Capital Total Amount	128-134	9(07)
46	Filler	135	X(01)
47	Filler	136	X(01)
48	Filler	137-143	X(07)

FIELD NUMBER	DATA ELEMENT NAME	LOCATION	COBOL PICTURE
49	Total Charges	144-150	9(07)
50	Covered Charges	151-157	9(07)
51	Reimbursement Amount	158-164	9(07)
52	Total Accommodations Charges	165-171	9(07)
53	Total Departmental Charges	172-178	9(07)
54	Accommodation Days Occurs 5 times	179-193	9(03)
55	Accommodation Charges Occurs 5 times	194-228	9(07)
56	Service Charges Occurs 25 times	229-403	9(07)
57	Intensive Care Indicator	404	X(01)
58	Coronary Care Indicator	405	X(01)
59	Pharmacy Indicator	406	9(01)
60	Transplant Indicator	407	9(01)
61	Radiology Indicator Occurs 6 times	408-413	9(01)
62	Outpatient Services Indicator	414	9(01)
63	Organ Indicator	415-416	X(02)
64	ESRD Setting Indicator Occurs 5 times	417-426	X(02)
65	Number of Diagnosis Codes	427-428	9(02)
66	Diagnostic Codes Occurs 9 times	429-473	X(05)
67	Surgery Indicator	474	X(01)
68	Number of Surgical Codes	475-476	9(02)
69	Filler	477	X(01)
70	Surgical Codes Occurs 6 times	478-501	X(04)
71	Filler	502	X(01)
72	Blood Furnished	503-505	9(03)
73	Filler	506	X(01)
74	DRG Code	507-509	9(03)
75	Discharge Destination	510-511	9(02)
76	Outlier Code/DRG Source	512	9(01)
77	Primary Payer Code	513	X(01)
78	MEDPAR ESRD Condition	514-515	9(02)
79	Source of Admission	516	X(01)
80	Type of Admission	517	X(01)

```
81        Intermediary Number            518-522      X(05)
82        Admission Diagnosis Code       523-527      X(05)
83        Filler                         528          X(01)
84        Filler                         529          X(01)
85        Admission To Death Interval    530-534      9(05)
86        Current DRG                    535-537      9(03)
87        Proposed/Final DRG             538-540      9(03)
88        Filler                         541-552      X(12)
89        National Provider ID           553-562      X(10)
```

EXPANDED MODIFIED MEDPAR

RECORD DATA DESCRIPTIONS

01   FILLER

(FOR FUTURE USE)

02   AGE

Description:

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

Coding Scheme:

```
Age is a one-position field with the following code:
        1 = less than 25
        2 = 25 - 44
        3 = 45 - 64
        4 = 65 - 69
        5 = 70 - 74
        6 = 75 - 79
        7 = 80 - 84
        8 = 85 - 89
        9 = 90 and over
```

Original Source:

SSA and RRB Beneficiary Record Systems

03   SEX

Description:

This field specifies the sex of the beneficiary.

Coding Scheme:

      0 - Unknown*
      1 - Male
      2 - Female

Original Source:

SSA and RRB Beneficiary Record Systems

Limitations:

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

```
04   RACE

Description:

This field specifies the beneficiary's race.

Coding Scheme:

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

Original Source:

SSA and RRB Beneficiary Record Systems

Limitations:

Unknown
```

05   MEDICARE STATUS CODE (MSC)

Description:

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

Coding Scheme:

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

```
21 - Disabled with ESRD
31 - ESRD only
```

Original Source:

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

Limitations:

Unknown

06 STATE

Description:

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

Coding Scheme:

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

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

Original Source:

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

Limitations:

Invalid or unknown states are coded "99."

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

The last three positions in this field contain blanks.

07   FILLER

(FOR FUTURE USE)

08   FILLER

                              (FOR FUTURE USE)

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
          1 = PPS

Original Source:

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

field indicates that this is a PPS provider.

Limitations:

Experience with the indicator shows that it was unreliable in 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, l987, the Alcohol/Drug units are no longer PPS-
exempt units.

16   STAY INDICATOR

Description:

This field specifies the type of stay.

Coding Scheme:

    S - Short stay
    L - Long stay
    N - SNF

Original Source:

Derived from Uniform Bill, Form HCFA-1450

Limitations:

Unknown

17 NUMBER OF BILLS

Description:

This field specifies the number of bills for a stay.

Coding Scheme:

Three-position field nnn, where n is a number

Original Source:

Generated from the stay record at Central Office

Limitations:

Unknown

18   FILLER

                              (FOR FUTURE USE)

19   FILLER

(FOR FUTURE USE)

20   FILLER

(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)

26   FILLER

(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:

Five-position field nnnnn, 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 nnn, 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 = 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

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)
    01 - Other organ acquisition (Revenue Code 0819)
    02 - General classification Revenue Code 0890)
    B1 - Bone donor bank (Revenue Code 0891)
    03 - Organ donor bank other than kidney (Revenue code 0892)
    S1 - Skin donor bank (Revenue Code 0893)
    04 - Other donor bank (Revenue Code 0899)
    Blank - no organ acquisition indication

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

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).

73   FILLER

(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 469 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)
43 - Discharged/transferred to a federal hospital
     (eff. 10/1/03)
50 - Hospice - home (eff. 10/96)
51 - Hospice - medical facility (eff. 10/96)
61 - Discharged/transferred within this institution
     to a hospital-based Medicare approved swing bed (eff.
     9/01)
62 - Discharged/transferred to an inpatient
     rehabilitation facility including distinct
     parts units of a hospital. (eff. 1/2002)
63 - Discharged/transferred to a long term care
     hospital. (eff. 1/2002)
64 - Discharged/transferred to a nursing facility
     certified under Medicaid but not under
     Medicare.(eff. 10/2002)
65 - Discharged/transferred to a psychiatric
     hospital or psychiatric distinct unit of a
     hospital.(eff. 1/2005)
66 - Discharged/transferred to a Critical
     Access Hospital (CAH). (eff. 1/1/06)
71 - Discharged/transferred/referred to another
     institution for outpatient services as
     specified by the discharge plan of care.
     (eff. 9/2001)
72 - Discharged/transferred/referred to this institution
     for outpatient services as specified by the
     discharge plan of care.(eff. 9/2001)

Original Source:

Uniform Bill, Form HCFA-1450

Limitations:

Unknown

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

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.
B - Transfer from another Home Health Agency -
The patient was admitted to this home
health agency as a transfer from another
home health agency.
C - Readmission to Same Home Health Agency -
The patient was readmitted to this home
health agency within the same home health
episode period.
D - Transfer from hospital inpatient in the
same facility resulting in a separate
claim to the payer - The patient was
admitted to this facility as a transfer
from hospital inpatient within this
facility resulting in a separate
claim to the payer.

  For Newborn Type of Admission

.

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

Original Source:

Uniform Bill, Form HCFA-1450

Limitations: Unknown

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

83   FILLER

(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 469 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 998 and DRG 999 are categories that could not be accurately

classified into valid DRG's.

(FOR FUTURE USE)

89   National Provider ID (NPI)

Description:

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

Coding Scheme:

Ten-position character field.

Original Source:

Uniform Bill

Limitations:

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

ATTACHMENTS

Attachment A

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

Step 1   Compute Age-of-Person

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

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

          OREC & CREC = MS CODE   OREC & CREC = MS CODE
           0   &   0 =   10   1   &   0 =   20

```
        0   &   1   =   10              1   &   1   =   20
        0   &   2   =   10              1   &   2   =   20
        0   &   3   =   10              1   &   3   =   20
        2   &   0   =   31              3   &   0   =   20
        2   &   1   =   20              3   &   1   =   20
        2   &   2   =   31              3   &   2   =   20
        2   &   3   =   20              3   &   3   =   20
```

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

Note:

Reason for Entitlement: End Stage Renal Disease Indicator:
   0 - OASI   0 - No ESRD
   1 - DIB   A - MBR
   2 - Renal   B - HI
   3 - DIB & Renal   C - NIH
                                    D - MBR & HI
Medicare Status Code: E - MBR & HI
   10 - Aged without ESRD   F - HI & NIH
   11 - Aged with ESRD   G - MBR, HI, & NIH
   20 - DIB without ESRD   H - OAS Clerical
   21 - DIB with ESRD   I - MBR/OAS Clerical
   31 - ESRD only   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
```

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
```

1

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.

STATE CODES

Code	State	Code	Territory
01	Alabama	47	Vermont
02	Alaska	48	Virgin Islands
03	Arizona	49	Virginia
04	Arkansas	50	Washington
05,55,75	California	51	West Virginia
06	Colorado	52	Wisconsin
07	Connecticut	53	Wyoming
08	Delaware	54	Africa
09	District of Columbia	56	Canada
10,68,69	Florida	57	Central America
11	Georgia		and West Indies
12	Hawaii	58	Europe
13	Idaho	59	Mexico
14,78	Illinois	60	Oceania
15	Indiana	61	Philippines
16,76	Iowa	62	South America
17,70	Kansas	63	U.S.
18	Kentucky		Possessions
19,71	Louisiana	64**	American Samoa
20	Maine	65**	Guam
21,80	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
23	Michigan		Marianas
24,77	Minnesota	98**	Guam

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

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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.