NATIONAL AMBULATORY MEDICAL CARE SURVEY LIST OF DATA ITEMS, 1973-2004

For survey years 1973-91, there are two public use files--one for patient visit data where each record contains information on a sampled patient visit and a second for drug mention data where each record represents a single drug mention along with its associated visit data. The second file is limited to those visits with mention of medication therapy. For the 1991 data, it is possible to link information on the drug file with information on the patient visit file. Beginning with the 1992 survey year, only one data file is produced annually that contains both patient visit and drug information.

Patient visit data

Data on the patient visit file reflect the NAMCS instrument or Patient Record form. Each file record contains all of the items in the following summary, including an inflation factor or patient visit weight. This weight must be used to obtain national estimates of health care utilization from the sample data Items without dates are available on the public use files for all survey years.

Patient visit file

Date of visit

Patient's age

Patient's sex

If female, is patient pregnant? (1997-2000)

Patient's race (revised in 1979 and 1999)

Patient's ethnicity (1979-present)

Does patient smoke cigarettes? (1991-96)

Does patient use tobacco? (2001-present)

Expected source(s) of payment (1985-present) (revised in 1995 and 1997)

Was authorization required for care? (1997-2000)

Are you the patient's primary care physician? (1997-present)

Does patient belong to an HMO? (1997-2000)

Is this a capitated visit? (1997-2000)

Was patient referred by another physician? (1977-present)

Has the physician seen patient before?

If yes, for same condition as this visit? (1973-1996)

How many past visits in the last 12 months? (2001-present)

Episode of care (2001-2004)

Do other physicians share patient's care for this problem? (2001-2004)

Major reason for the visit (1973-76, 1979-81, 1997-present)

Patient's reason(s) for the visit (up to three) (classification revised in 1979)

Is visit injury related? (1991-present)

Place of occurrence of injury (1995-2000)

Is injury work related? (1995-2000)

Is injury intentional? (1997-2000)

Cause of injury verbatim text (1997-2004)

Cause of injury (up to three) (ICD-9-CM E codes) (1995-2004)

Physician's diagnoses (up to three) (ICD-9-CM used from 1979-present)

Is diagnosis probable, questionable, or ruleout? (1997-present)

Does patient now have:

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depression (1991-92, 1995-96)
     hypertension (1991-92, 1995-96)
     hypercholesterolemia (1991-92)
     obesity (1991-96) asthma (1993-94)
     diabetes (1993-96)
     HIV (1993-96)
     osteoporosis (1993-94)
     arthritis (1995-96) COPD (1995-96)
     chronic renal failure (1995-96)
     hyperactivity/ADD (1995-96)
Ambulatory surgical procedures (1991-present) (ICD-9-CM procedure codes)
 (reported under "Tests, Surgical and Non-Surgical Procedures and Therapies" in
 1993-94)
Diagnostic/screening services<sup>1</sup>
(includes patient's temperature and blood pressure readings [2003-present])
Counseling/advice<sup>1</sup>
Selected types of therapy<sup>1</sup>
Medications provided or prescribed (up to 8 in 1980; up to 5 in 1985-1994; up to 6
 in 1995-2002; up to 8 in 2003-present)
Is this a new medication for the patient? (1985-1992)
Were any drugs from formulary list? (1997)
Additional drug characteristics for each medication coded (1992-present):
     Generic name code
     Prescription status code
     Controlled substance status code
     Composition status code
     Therapeutic class (from National Drug Code Directory) Ingredient codes
       (up to 5)
Providers seen this visit (1995-present)
Disposition of the visit (1973-1996, 1999-present)
Duration of the visit
Patient visit weight (an inflation factor assigned to the visit)
Geographic region of the visit
Metropolitan statistical area (MSA) or non-MSA location of the visit
Seriousness of the problem (1973-78)
Time since onset of the complaint (1977-78)
Accidental injury or product-related illness (1979)
Patient-physician linking code (1991-present)
Physician specialty
Type of doctor (doctor of medicine or osteopathy)
Type of practice (solo, partnership, group) (1973-85)
Type of office setting for this visit (1997-present)
Solo practice? (1997-present)
Employment status of physician (1997-present)
Who owns this office? (1997-present)
Is lab testing performed at this office? (1997-present)
Did physician make home visits in last full week of practice? (2001-present)
Did physician make hospital visits in last full week of practice? (2001-present)
Did physician do telephone consults in last full week of practice? (2001-present)
Did physician do email consults in last full week of practice? (2001-present)
Does practice use electronic medical records? (2003-present)
Does practice submit claims electronically? (2003-present)
Percent of patient care revenue from Medicare (2003-present)
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Percent of patient care revenue from Medicaid (2003-present)

Percent of patient care revenue from private insurance (2003-present)

Percent of patient care revenue from other source (2003-present)

How many managed care contracts? (2003-present)

Percent of patient care revenue from managed care (2003-present)

Is physician currently accepting new patients? (2003-present)

For new patients, physician accepts: capitated payment (2003-present)

For new patients, physician accepts: non-capitated (2003-present)

For new patients, physician accepts: Medicare (2003-present)

For new patients, physician accepts: Medicaid (2003-present)

For new patients, physician accepts: Workers comp (2003-present)

For new patients, physician accepts: self-pay (2003-present)"

For new patients, physician accepts: no charge (2003-present)

Difficulty referring Medicaid patients for specialty consultation (2003-present)

Difficulty referring Medicare patients for specialty consultation (2003-present)

Difficulty referring private insurance patients for specialty consultation (2003-present)

Difficulty referring uninsured patients for specialty consultation (2003-present)

Who completed the Patient Record forms? (1998-present)

Setting type (2001-present)

Intentionality of injury recode (based on E code) (1997-2004)

Race recode (1993-present)

Physician specialty recode (1993-present)

Age recode (1995-present)

Age in days for patients less than one year (1995-present)

Masked sample design variables (1993-present)

Drug data

Data on the drug mention file concern only those office visits at which one or more medications were ordered, provided, or continued. There is one record for each drug entered on the Patient Record form. A single office visit in 1985 could have up to five drugs entered on the form, resulting in five separate records on the file. On the other hand, if there were no drugs entered on the form for a particular office visit, there would be no records on the drug file for that visit. Each file record contains all of the items in the following summary, including an inflation factor or drug weight. This weight must be used to obtain national estimates of drug utilization from the sample data.

Drug mention file (1980-81, 1985, and 1989-91)

Items without dates are available on the public use files for all survey years.

Medication/drug entry code

Medication/drug entry name

Generic name code

Generic name Brand name (1980-81)

Entry status code

Prescription status code

Controlled substance status code

Composition status code Ingredient codes (up to 5)

Number of drugs coded on encounter form

Drug weight (an inflation factor assigned to each drug record)

Date of visit

Patient's age

Patient's sex Patient's race (revised in 1979) Patient's ethnicity Expected source(s) of payment (1985 to the present) Was patient referred by another physician? Patient's reason(s) for the visit (up to three) Physician's diagnoses (up to three) (ICD-9-CM) Has the physician seen patient before? If yes, for same condition as this visit? Diagnostic/screening services¹ Counseling/advice¹ Selected types of therapy¹ Disposition of the visit (revised in 1995) Duration of the visit Geographic region of the visit Metropolitan statistical area (MSA) or non-MSA location of the visit Major reason for the visit (1980-81) Is visit injury related? (1991) Does patient smoke cigarettes? (1991) Ambulatory surgical procedures (ICD-9-CM procedure codes) (1991) Does patient now have: depression (1991) hypertension (1991) hypercholesterolemia (1991) obesity (1991) Patient-physician linking code (1991) Physician specialty Type of doctor (doctor of medicine or osteopathy Type of practice (solo, partnership, group) (1980-85)

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¹Updated and/or reformatted periodically in order to keep pace with the current spectrum of physician services being provided and to reflect changing health data needs. Most years include a combination of checkbox and open-ended responses, with the latter coded according to the ICD-9-CM procedure classification.