Notes for MEDPAR

The MEDPAR expense files were received from HCFA in 4 different formats.

1986 were shipped as a length 330 file.
1987-1990 were shipped as a length 500 file.
1991-1997 and 1998-2001 for 5% non-cancer records were shipped as a length 788 file.
1998-2001 for cancer records were shipped as a length 838 file.
2002-2010 were shipped as a length 1376 file.

If you have received MEDPAR files in previous data linkages note that starting in the 2008 data linkage these variables are no longer included in the MEDPAR data files:

MEDPAR Beneficiary Sex Code (SEX)
MEDPAR Beneficiary Race Code (RACE)
MEDPAR Internal Use SSI Indicator Code (SSI_IND)
MEDPAR Internal Use SSI Day Count (SSI_DAYS)
MEDPAR Total PPS Capital Amount (CAPACC92)
Cost Report Organ Acquisition Charges (CHR_CRO)
Total Per Diem (TOTALPD)
IME (IMECOST)
Acquisition Charges (AQUCHRGS)
MEDPAR Private Room Day Count (PRIVDAYS)
MEDPAR Semiprivate Room Day Count (SEMIDAYS)
MEDPAR Ward Day Count (WARDDAYS)
MEDPAR Private Room Charge Amount (PRIVCHRG)
MEDPAR Semi-Private Room Charge Amount (SEMICHRG)
MEDPAR Ward Charge Amount (WARDCHRG)
MEDPAR Other Service Charge Amount (OTHRCHRG)
MEDPAR Medical/Surgical Supply Charge Amount (MDSRCHRG)
MEDPAR DME Charge Amount (DMECHRG)
MEDPAR Used DME Charge Amount (UDMECHRG)
HMO Number (HMONUMBR)
HMO Option Code (HMOOPCDE)
Unibill Indicator (UNIBILL)
Query Code (QUERYCD)
Year Bill Approved (YRAPPRVD)
MEDPAR Internal Use (By IPSB) Code (IMCABIN)
MEDPAR Internal Use File Date Code (DATADATE)
MEDPAR Internal Use Sample Size Code (SAMPSIZE)

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|---|---|---|---|
| **** | Medicare Provider Analysis and Review (MEDPAR) Expanded Modified Record | REC 1032 | The representation of a beneficiary stay in an Inpatient hospital or in a skilled nursing facility (SNF) which may include one or more final action claims. |

The 1995 Medicare provider analysis and review (MEDPAR) file contains data from claims for services provided to Medicare beneficiaries admitted to Medicare-certified hospitals and skilled nursing facilities (SNF). The file is created quarterly in March, June, September, and December, and is generally available two weeks after the end of the quarter. Each MEDPAR record represents a beneficiary stay in an Inpatient hospital (where discharged) or in a SNF (may be ‘still a patient'; complete discharge data not always received), and may include one claim or multiple claims. (Approximately 95% of Inpatient MEDPAR records and 50% of SNF MEDPAR records involve a single claim.)

Beginning in June 1995, the Inpatient and SNF claims from the national claims history (NCH) 100% nearline file became the source of MEDPAR. Also effective June, 1995, a MEDPAR record represents final action claims data in which all adjustments have been resolved (thereby eliminating credit-only situations).

(Prior to June 1995, MEDPAR was created from claims from the Medicare quality assurance (MQA) system; a MEDPAR record represented an accumulation of adjustment claims, sometimes including credit-only stays.)

Effective with the 9/96 update the 1995 MEDPAR was created as follows:

1. Each month Inpatient and SNF claims are accumulated from the NCH nearline repository.
2. At the end of each quarter, the monthly files are merged into a database containing all claims for the current year and prior two years. The database is processed through the final action algorithms.

3. The final-actioned database is split into two segments for each year. Inpatient claims with discharge dates and SNF claims with admission dates in January through September are in the first segment; claims with dates in October through December are in the second segment. This allows for the creation of fiscal year or calendar year files as needed.
4. The claims remaining from the final action processing are collapsed by claim number, admission date, and provider number (all in ascending order) to create a stay record. The records are further sorted by claim from date, claim thru date, (both in ascending order), HCFA process date (descending), and query code (descending); and the results are used to create MEDPAR.

For the 6/95 through the 6/96 updates the 1995 MEDPAR was created as follows:

* Each month Inpatient and SNF claims are accumulated from the NCH nearline repository.

* At the end of each quarter, the monthly files are merged into a database containing all claims for the current year and prior two years. The database is split into two segments for each year. Inpatient claims with discharge dates and SNF claims with admission dates in January through September are in the first segment; claims with dates in October through December are in the second segment. This allows for the creation of fiscal year or calendar year files as needed.

* The segments are processed through the final action algorithms. The claims remaining from the final action processing are collapsed by claim number, admission date, and provider number (all in ascending order) to create a stay record. The records are further sorted by claim from date, claim thru date, (both in ascending order), HCFA process process date (descending), and query code (descending); and the results are used to create MEDPAR.

| COL | FIELD | LENGTH | NOTES |
|---|---|---|---|
| 1 | Patient ID<br>**(patient_id)** | 11 | Use First 10 Characters only for SEER cases. |
| | **SEER Cases (Patient ID)** | | |
| 1 | SEER Registry | 2 | 02 = Connecticut<br>20 = Detroit<br>21 = Hawaii<br>22 = Iowa<br>23 = New Mexico<br>25 = Seattle<br>26 = Utah<br>42 = Kentucky<br>43 = Louisiana<br>44 = New Jersey<br>87 = Georgia<br>88 = California |
| 3 | Case Number | 8 | Encrypted SEER Case Number |
| 11 | Filler | 1 | Blank Space |
| | **Non Cancer Patients – Patient ID** | | |
| 1 | HIC **(Patient ID)** | 11 | Encrypted ID for Non Cancer Patients |
| 12 | MEDPAR Beneficiary Age<br>**(AGE)** | 3 | The beneficiary’s age as of date of admission. |
| 15 | MEDPAR Beneficiary Medicare Status Code<br>**(MDCRSTAT)** | 2 | The CWF-derived reason for a beneficiary’s entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).<br><br>CODES:<br>10 = Aged without ESRD<br>11 = Aged with ESRD<br>20 = Disabled without ESRD<br>21 = Disabled with ESRD<br>31 = ESRD only |
| 17 | MEDPAR Beneficiary Residence SSA Standard County Code **(STDSTATE)** | 2 | State of Beneficiary’s residence, SSA Standard Code. (Refer to Appendix table STATE_CD) |
| 19 | MEDPAR Beneficiary Residence SSA Standard County Code **(STD_CNTY)** | 3 | County of Beneficiary’s residence, SSA Standard Code. |

| COL | FIELD | LENGTH | NOTES |
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| 22 | MEDPAR Beneficiary Mailing Contact Zip Code **(BENE_ZIP)** | 5 | Beneficiary's mailing address zip code.<br>***Special Permission Required.** |
| 27 | MEDPAR Admission Day Code **(ADMDAY)** | 1 | The code indicating the day of the week on which the beneficiary was admitted to a facility.<br><br>CODES:<br>1 = Sunday<br>2 = Monday<br>3 = Tuesday<br>4 = Wednesday<br>5 = Thursday<br>6 = Friday<br>7 = Saturday |
| 28 | MEDPAR Beneficiary Discharge Status Code **(DSCHGSTA)** | 1 | The code used to identify the status of the patient as of the CLM_THRU_DT.<br><br>CODES:<br>A = Discharged alive (claim status code other than 20 or 30)<br>B = Discharged dead (claim status code = 20)<br>C = still a patient (claim status code = 30) |
| 29 | MEDPAR GHO Paid Code **(GHOPD)** | 1 | The code indicating whether or not a GHO has paid the provider for the claim(s).<br><br>CODES :<br>1 = GHO has paid the provider<br>Blank Or 0 = GHO has not paid the provider |
| 30 | MEDPAR PPS Indicator Code **(PPSIND)** | 1 | The code indicating whether or not the facility is being paid under the prospective payment system (PPS).<br><br>CODES:<br>0 = Non PPS<br>2 = PPS |

| COL | FIELD | LENGTH | NOTES |
|---|---|---|---|
| 31 | MEDPAR Provider Number Group **(PROVIDER)** | 6 | The provider number is encrypted.<br>*** Special Permission is required to receive unencrypted data.**<br><br>The first two positions of the provider number identify the state of the institutional provider. The third to 6th positions of the provider number have been replaced with a randomly generated number to prevent the identification of the hospital. |
| 37 | MEDPAR Provider Number Special Unit Code **(PROVCODE)** | 1 | The code identifying the special numbering system for units of hospitals that are excluded from PPS or hospitals with SNF swing-bed designation.<br><br>CODES:<br>S = PPS-exempt psychiatric unit<br>T = PPS-exempt rehabilitation unit<br>U = Swing-bed short-term/acute care hospital<br>W = Swing-bed long-term hospital<br>Y = Swing-bed rehabilitation hospital<br>Z = Swing-bed rural primary care hospital: eff. 10/97 changed to critical access hospitals<br>Blanks = Not PPS-exempt or swing-bed designation |
| 38 | MEDPAR Short Stay/Long Stay/SNF Indicator Code **(SNFIND)** | 1 | The code indicating whether the stay is a short stay, long stay or SNF.<br><br>CODES:<br>N = SNF Stay (Prvdr3 = 5, 6, U, W, Y, or Z)<br>S = Short-Stay (Prvdr3 = O, S, T)<br>L = Long-Stay (All Others) |
| 39 | STAY FINAL ACTION CLAIMS COUNT **(NUMBILLS)** | 4 | The count of the number of claim records (final action) included in the stay. |
| 43 | LATEST CLAIM ACCRETION MONTH **(ACT_M, ACT_D, ACT_Y)** | 8 | The date the latest claim record included in the stay was accreted (posted/processed) to the beneficiary master record at the CWF host).<br>MMDDYYYY |

| COL | FIELD | LENGTH | NOTES |
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| 51 | MEDPAR Beneficiary Medicare Benefit Exhausted Date (1987+) **(BEN_M, BEN_D, BEN_Y)** | 8 | The last date for which the beneficiary had Medicare coverage. This field is completed only where benefits were exhausted before the discharge date and during the period covered by stay. MMDDYYYY |
| 59 | MEDPAR SNF Qualification from Date (1987+) **(SNF_M, SNF_D, SNF_Y)** | 8 | The beginning date of the beneficiary's qualifying stay. For Inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to the qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'a', or at least three days in a row if the source of admission is other than an 'a'. MMDDYYYY |
| 67 | MEDPAR SNF Qualification Through Date (1987+) **(SNT_M, SNT_D, SNT_Y)** | 8 | The ending date of the beneficiary's qualifying stay. For Inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to the qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than an 'A'. MMDDYYYY |
| 75 | MEDPAR Admission Date **(ADM_M, ADM_D, ADM_Y)** | 8 | The date the beneficiary was admitted for Inpatient care or the date that care started. |
| 83 | MEDPAR Discharge Date **(DIS_M, DIS_D, DIS_Y)** | 8 | The date on which the beneficiary was discharged or died. MMDDYYYY<br><br>NOTE: This field comes from the highest claim thru date that is present on the claim records included in the stay, where the claim status is other than '30' (still patient) on the last claim record included in the stay. Inpatient claims will always have a discharge date: SNF claims could have a zero date. |
| 91 | MEDPAR Beneficiary Death Date **(DOD_M, DOD_D, DOD_Y)** | 8 | The date the beneficiary died. MMDDYYYY |
| 99 | MEDPAR Covered Level Care Thru Date **(CVR_M, CVR_D, CVR_Y)** | 8 | The date on which a covered level of care ended in a SNF. MMDDYYYY |

| COL | FIELD | LENGTH | NOTES |
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| 107 | MEDPAR Beneficiary Death Date Verified Code **(HIMASIND)** | 1 | The code indicating whether the beneficiary's date of death has been verified or originated from a claim record.<br><br>CODES:<br>V = Date of death verified (EDB received DOD from SSA's MBR)<br>B = Date of death taken from claim (EDB received DOD from claim)<br>N = Date of death not verified (neither V or B applicable, but claim status code indicated death)<br>Space = No date of death indicated |
| 108 | MEDPAR Length of Stay Day Count **(LOS)** | 6 | The count in days of the total length of a beneficiary's stay in a hospital or SNF. |
| 114 | MEDPAR Outlier Day Count **(OUTLRDAY)** | 4 | The count of the number of days paid as outliers (either a day or cost outlier) under PPS beyond the DRG threshold. |
| 118 | MEDPAR Utilization Day Count **(CVRDDAYS)** | 4 | The count of the number of covered days of care that is chargeable to Medicare utilization for the stay. |
| 122 | MEDPAR Beneficiary Total Coinsurance Day Count **(COINDAYS)** | 4 | The count of the total number of coinsurance days involved with the beneficiary's stay in a facility. For Inpatient services, the beneficiary is liable for a daily coinsurance amount after the 60th day and before the 91st day in a single spell of illness; for SNF services, the beneficiary is liable for a daily coinsurance amount after the 20th day and before the 101st day in a single spell of illness. |
| 126 | MEDPAR Beneficary LRD Used Count **(LIFRESDY)** | 4 | The count of the number of lifetime reserve day (LRD) used by the beneficiary for this stay. |
| 130 | MEDPAR Beneficiary Part A Coinsurance Liability Amount **(COINAMT)** | 8 | The amount of money (rounded to whole dollars) identified as the beneficiary's liability for part A coinsurance for the stay. |
| 138 | MEDPAR Beneficiary Inpatient Deductible Liability Amount **(INPATDED)** | 8 | The amount of money (rounded to whole dollars) identified as the beneficiary's liability for Inpatient deductible for the stay. |
| 146 | MEDPAR Beneficiary Blood Deductible Liability Amount (1987+) **(BLOODDED)** | 8 | The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the blood deductible for the stay. |

| COL | FIELD | LENGTH | NOTES |
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| 154 | MEDPAR Beneficiary Primary Payer Amount **(PRIPYAMT)** | 8 | The amount of payment (rounded to whole dollars) made on behalf of the beneficiary by a primary payer other than Medicare, which has been applied to the covered Medicare charges for the stay. |
| 162 | MEDPAR DRG Outlier Approved Payment Amount **(OUTLRAMT**) | 8 | The amount of additional payment (rounded to the whole dollars) approved due to an outlier situation over the DRG allowance for the stay. |
| 170 | MEDPAR Inpatient Disproportionate Share Amount (1987+) **(DISHRAMT)** | 8 | The amount paid over the DRG amount (rounded to whole dollars for the disproportionate share hospital for the stay. |
| 178 | MEDPAR Indirect Medical Education (IME) Amount **(INDMEDED)** | 8 | The amount of additional payment (rounded to whole dollars) made to teaching hospitals for IME for the stay. |
| 186 | MEDPAR DRG Price Amount **(DRGPRICE)** | 8 | The amount (called the 'DRG price' for purposes of MEDPAR analysis) that would have been paid if no deductibles, coinsurance, primary payers, or outliers were involved (rounded to whole dollars). |
| 194 | MEDPAR Total Pass Through Amount (1987+) **(PASSTHRU)** | 8 | The total of all claim pass through amounts rounded to whole dollars) for the stay. |
| 202 | MEDPAR Low Volume Payment Amount **(LOW_PAMT)** | 10.2 | MEDPAR IP low volume payment amount |
| 212 | MEDPAR Total Charge Amount **(TOTCHRGS)** | 8 | The total amount (rounded to whole dollars) of all charges (covered and noncovered) for all services provided to the beneficiary for the stay. |
| 220 | MEDPAR Total Covered Charge Amount **(CVRDCHRG)** | 8 | The portion of the total charges amount (rounded to whole dollars) that is covered by Medicare for the stay. |

| COL | FIELD | LENGTH | NOTES |
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| 228 | MEDPAR Medicare Payment Amount **(REIMBAMT)** | 8 | Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the fi; and represents what was paid to the institutional provider, with the exceptions noted below.<br>**NOTE: in some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)<br><br>Under ip PPS, Inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the pricer program. On the ip PPS claim, the payment amount includes the DRG outlier approved, payment amount, disproportionate share (since 5/1/86), in-direct medical education (since 10/1/88), total PPS capital (since 10/1/91). It does not include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement. |

| COL | FIELD | LENGTH | NOTES |
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| | MEDPAR Medicare Payment Amount **(REIMBAMT) (CONTINUED)** | | Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as rugs III. For the SNF PPS claim, the SNF pricer will calculate/return the rate for each revenue center line item with revenue center code = ‘0022’; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code ‘0022’ to determine the total claim payment amount.<br><br>Exceptions: For claims involving demos and bba encounter data, the amount reported in this field May not just represent the actual provider payment.<br><br>For demo ids ‘01’, ‘02’, ‘03’, ‘04’ – claims contain amount paid to the provider, except that special ‘differentials’ paid outside the normal payment system are not included.<br><br>For demo ids ‘05’, ‘15’ – encounter data ‘claims’ contain amount Medicare would have paid under ffs, instead of the actual payment to the MCO.<br><br>For demo ids ‘06’, ‘07’, ‘08’ – claims contain actual provider payment but represent a special negotiated bundled payment for both part a and part b services. To identify what the conventional provider part a payment would have been, check value code = ‘y4’.<br><br>For bba encounter data (non-demo) – ‘claims’ contain amount Medicare would have paid under ffs, instead of the actual payment to the bba plan. |
| 236 | MEDPAR All Accommodations Total Charge Amount **(TOTACCHR)** | 8 | The total charge amount (rounded to whole dollars) for all accommodations (routine hospital room and board charges for general care, coronary care and /or intensive care units) related to a beneficiary’s stay. |

| COL | FIELD | LENGTH | NOTES |
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| 244 | MEDPAR Departmental Total Charge Amount **(TOTDPCHR)** | 8 | The total charge amount (rounded to whole dollars) for all ancillary departments (other than routine room and board, CCU, and ICU) related to a beneficiary's stay. |
| 252 | MEDPAR Intensive Care Day Count **(INCRDAYS)** | 4 | The count of the number of intensive care days used by the beneficiary for the stay. |
| 256 | MEDPAR Coronary Care Day Count **(CRCRDAYS)** | 4 | The count of the number of coronary care days used by the beneficiary for the stay. |
| 260 | MEDPAR Intensive Care Charge Amount **(INCRCHRG)** | 8 | The charge amount (rounded to whole dollars) for intensive care accommodations related to a beneficiary's stay. |
| 268 | MEDPAR Coronary Care Charge Amount **(CRCRCHRG)** | 8 | The charge amount (rounded to whole dollars) for coronary care accommodations related to a beneficiary's stay. |
| 276 | MEDPAR Pharmacy Charge Amount **(PHRMCHRG)** | 8 | The charge amount (rounded to whole dollars) for pharmaceutical costs related to the beneficiary's stay. |
| 284 | MEDPAR Physical Therapy Charge Amount **(PHYTCHRG)** | 8 | The charge amount (rounded to whole dollars) for physical therapy services provided during the beneficiary's stay. |
| 292 | MEDPAR Occupational Therapy Charge Amount **(OCPTCHRG)** | 8 | The charge amount (rounded to whole dollars) for occupational therapy services provided during the beneficiary's stay. |
| 300 | MEDPAR Speech Pathology Charge Amount **(SPPTCHRG)** | 8 | The charge amount (rounded to whole dollars) for speech pathology services (speech, language, audiology) provided during the beneficiary's stay. |
| 308 | MEDPAR Inhalation Therapy Charge Amount **(INHTCHRG)** | 8 | The charge amount (rounded to whole dollars) for inhalation therapy services (respiratory and pulmonary function) provided during the beneficiary's stay. |
| 316 | MEDPAR Blood Charge Amount **(BLDDCHRG)** | 8 | The charge amount (rounded to whole dollars) for blood provided during the beneficiary's stay. |
| 324 | MEDPAR Blood Administration Charge Amount **(BLADCHRG)** | 8 | The charge amount (rounded to whole dollars) for blood storage and processing related to the beneficiary's stay. |

| COL | FIELD | LENGTH | NOTES |
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| 332 | MEDPAR Operating Room Charge Amount **(OPRTCHRG)** | 8 | The charge amount (rounded to whole dollars) for the operating room, recovery room, and labor room delivery used by the beneficiary during the stay. |
| 340 | MEDPAR Lithotripsy Charge Amount (1987+) **(LITHCHRG)** | 8 | The charge amount (rounded to whole dollars) for lithotripsy services provided during the beneficiary's stay. |
| 348 | MEDPAR Cardiology Charge Amount (1987+) **(CARDCHRG)** | 8 | The charge amount (rounded to whole dollars) for cardiology services and electrocardiogram(s) provided during the beneficiary's stay. |
| 356 | MEDPAR Anesthesia Charge Amount **(ANSTCHRG)** | 8 | The charge amount (rounded to whole dollars) for anesthesia services provided during the beneficiary's stay. |
| 364 | MEDPAR Laboratory Charge Amount **(LABRCHRG)** | 8 | The charge amount (rounded to whole dollars) for laboratory costs related to the beneficiary's stay. |
| 372 | MEDPAR Radiology Charge Amount **(RADICHRG)** | 8 | The charge amount (rounded to whole dollars) for radiology costs (including oncology, excluding MRI) related to the beneficiary's stay. |
| 380 | MEDPAR Outpatient Service Charges **(OPSRCHRG)** | 8 | The charge amount (rounded to whole dollars) for outpatient services provided during the beneficiary's stay. |
| 388 | MEDPAR MRI Charge Amount (1987+) **(MRICHRG)** | 8 | The charge amount (rounded to whole dollars) for MRI services provided during the beneficiary's stay. |
| 396 | MEDPAR Emergency Room Charge Amount (1987+) **(EMRMCHRG)** | 8 | The charge amount (rounded to whole dollars) for emergency room services provided during the beneficiary's stay. |
| 404 | MEDPAR Ambulance Charge Amount (1987+) **(AMBLCHRG)** | 8 | The charge amount (rounded to whole dollars) for ambulance services related to a beneficiary's stay. |
| 412 | MEDPAR Professional Fees Charge Amount **(PROFFEES)** | 8 | The charge amount (rounded to whole dollars) for professional fees related to a beneficiary's stay. |
| 420 | MEDPAR Organ Acquisition Charge Amount **(ORAQCHRG)** | 8 | The charge amount (rounded to whole dollars) for organ acquisition or other donor bank services related to a beneficiary's stay. |

| COL | FIELD | LENGTH | NOTES |
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| 428 | MEDPAR ESRD Revenue Setting Charge Amount (1987+) **(ESRDCHRG)** | 8 | The charge amount (rounded to whole dollars) for ESRD services (other than organ acquisition and other donor bank) related to the beneficiary's stay. |
| 436 | MEDPAR Clinic Visit Charge Amount **(CLVTCHRG)** | 8 | The charge amount (rounded to whole dollars) for clinic visits (e.g., visits to chronic pain or dental centers or to clinics providing psychiatric, ob-gyn, pediatric services) related to the beneficiary's stay. |
| 444 | MEDPAR Intensive Care Unit (ICU) Indicator Code (1987+) **(INCREIND)** | 1 | The code indicating that the beneficiary has spent time under intensive care during the stay. It also specifies the type of ICU.<br><br>CODES:<br>0 = General (revenue center 0200)<br>1 = Surgical (revenue center 0201)<br>2 = Medical (revenue center 0202)<br>3 = Pediatric (revenue center 0203)<br>4 = Psychiatric (revenue center 0204)<br>6 = Intermediate ICU (revenue center 0206) prior to 12/96 update was 'post ICU'<br>7 = Burn care (revenue center 0207)<br>8 = Trauma (revenue center 0208)<br>9 = Other intensive care (revenue code 0209)<br>BLANK = No intensive care indication |
| 445 | MEDPAR Coronary Care Indicator Code (1987+) **(CRCREIND)** | 1 | The code indicating that the beneficiary has spent time under coronary care during the stay. It also specifies the type of coronary care unit.<br><br>CODES:<br>BLANK = No coronary care indication<br>0 = General (revenue code 0210)<br>1 = Myocardial (revenue code 0211)<br>2 = Pulmonary care (revenue code 0212)<br>3 = Heart transplant (revenue code 0213)<br>4 = Intermediate CCU (revenue code 0214) prior to 12/96 update was 'post ccu'<br>9 = Other coronary care (revenue code 0219) |

| COL | FIELD | LENGTH | NOTES |
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| 446 | MEDPAR Pharmacy Indicator Code (1987+) **(PHRMYIND)** | 1 | The code indicating whether or not the beneficiary received drugs during the stay. It also specifies the type of drugs.<br>CODES:<br>0 = No drugs (revenue code other than those listed below)<br>1 = General drugs and/pr IV therapy (revenue code 025x, 026x)<br>2 = Erythropoietin (epoetin: revenue code 0630,<br>0635, 0637, 0639)<br>3 = Blood clotting drugs (revenue code 0636)<br>4 = General drugs and/or IV therapy; and epoetin (combination of values 1 and 2<br>5 = General drugs and/or IV therapy; and blood clotting drugs (combination of values 1 and 3) |
| 447 | MEDPAR Transplant Indictor Code (1987+) **(TRNSPIND)** | 1 | The code indicating whether or not the beneficiary received an organ transplant during the stay.<br>CODES:<br>0 = No organ or kidney transplant (revenue code not 0362 or 0367)<br>2 = Organ transplant other than kidney (revenue code 0362)<br>7 = Kidney transplant (revenue code 0367) |
| 448 | MEDPAR Radiology Oncology Indicator Switch (1987+) **(ONCLGIND)** | 1 | The switch indicating whether or not the beneficiary received radiology oncology services during the stay.<br><br>CODES:<br>0 = No radiology-oncology (revenue code not 028x)<br>1 = Yes radiology-oncology (revenue code 028x) |

| COL | FIELD | LENGTH | NOTES |
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| 449 | MEDPAR Radiology Diagnostic Indicator Switch (1987+) **(RADDGIND)** | 1 | The switch indicating whether or not the beneficiary received radiology diagnostic services during the stay.<br><br>CODES:<br>0 = No radiology-diagnostic (revenue code not032x)<br>1 = Yes radiology-diagnostic (revenue code 032x) |
| 450 | MEDPAR Radiology Therapeutic Indicator Switch (1987+) **(RADTHIND)** | 1 | The switch indicating whether or not the beneficiary received radiology therapeutic services during the stay.<br><br>CODES:<br>0 = No radiology-therapeutic (revenue code not 033x)<br>1 = Yes radiology-therapeutic (revenue code 033x) |
| 451 | MEDPAR Radiology Nuclear Medicine Indicator Switch (1987+) **(NUCMDIND)** | 1 | The switch indicating whether or not the beneficiary received radiology nuclear medicine services during the stay.<br><br>CODES:<br>0 = No nuclear medicine (revenue code not 034x)<br>1 = Yes nuclear medicine (revenue code 034x) |
| 452 | MEDPAR Radiology CT Scan Indicator Switch (1987+) **(CTSCNIND)** | 1 | The switch indicating whether or not the beneficiary received radiology computed tomographic (CT) scan services during the stay.<br><br>CODES:<br>0 = No radiology CT scan (revenue code not 035x)<br>1 = Yes radiology CT scan (revenue code 035x) |

| COL | FIELD | LENGTH | NOTES |
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| 453 | MEDPAR Radiology Other Imaging Indicator Switch (1987+) **(OIMSRIND)** | 1 | The switch indicating whether or not the beneficiary received radiology other imaging services during the stay.<br><br>CODES:<br>0 = No other imaging services (revenue code not 040x)<br>1 = Yes other imaging services (revenue code 040x) |
| 454 | MEDPAR Outpatient Services Indicator Code **(OUTSRIND)** | 1 | The code indicating the type of organ acquisition received by the beneficiary during the stay. |
| 455 | MEDPAR Organ Acquisition Indicator Code (1987+) **(ORGANIND)** | 2 | The code indicating the type of organ acquisition received by the beneficiary during the stay.<br><br>CODES:<br>K1 = General classification (revenue code 0810)<br>K2 = Living donor kidney (revenue code 0811)<br>K3 = Cadaver donor kidney (revenue code 0812)<br>K4 = Unknown donor kidney (revenue code 081<br>K5 = Other kidney acquisition (revenue code 0814)<br>H1 = Cadaver donor heart (revenue code 0815)<br>H2 = Other heart acquisition (revenue code 0816)<br>L1 = Donor liver (revenue code 0817)<br>01 = Other organ acquisition (revenue code 0819)<br>02 = General acquisition (revenue code 0890)<br>B1 = Bone donor bank (revenue code 0891)<br>03 = Organ donor bank other than kidney (revenue code 0892)<br>S1 = Skin donor bank (revenue code 0893)<br>04 = Other donor bank (revenue code 0899)<br>BLANK = No organ acquisition indication |

| COL | FIELD | LENGTH | NOTES |
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| 457 | MEDPAR ESRD Setting Indicator Code (1987+) **(ESRDSET1-ESRDSET2)** | 2*2 | The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present. This MEDPAR file only retains the first two.<br>CODES:<br>00 = Ip renal dialysis-general (revenue code 0800)<br>01 = Ip renal dialysis-hemodialysis (revenue code 0801) 02 = Ip renal dialysis-peritoneal (non-capd: revenue code 0802)<br>03 = Ip renal dialysis-capd (revenue code 0803) 04 = Ip renal dialysis-ccpd (revenue code 0804) 09 = Ip renal dialysis-other (revenue code 0809) 20 = Hemodialysis-op-general (revenue code 0820)<br>21 = Hemodialysis-op-hemodialysis/composite (revenue code 0821)<br>22 = Hemodialysis-op-home supplies (revenue code 0822)<br>23 = Hemodialysis-op-home equipment (revenue code 0823)<br>24 = Hemodialysis-op-maintenance/100% (revenue code 0824<br>25 = Hemodialysis-op-support services (revenue code 0825)<br>29 = Hemodialysis-op-other (revenue code 0829)<br>30 = Peritoneal-op/home-general (revenue code 0830)<br>31 = Peritoneal-op/home-peritoneal/composite (revenue code 0831)<br>32 = Peritoneal-op/home-home supplies (revenue code 0832)<br>33 = Peritoneal-op/home-home equipment (revenue code 0833)<br>34 = Peritoneal-op/home-maintenance/100% (revenue code 0834)<br>35 = Peritoneal-op/home-support services (revenue code 0835)<br>39 = Peritoneal-op/home-other (revenue code 0839) |

| COL | FIELD | LENGTH | NOTES |
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| | MEDPAR ESRD Setting Indicator Code (1987+) **(ESRDSET1-ESRDSET2) (CONTINUED)** | | 40 = Capd-op-capd/general (revenue code 0840)<br>41 = Capd-op-capd/composite<br>42 = Capd-op-home supplies (revenue code 0842) |
| 461 | POA diagnosis Indicator Count **(POADXCNT)** | 2 | Claim Present on Admission Indicator Code Count |
| 463 | Present on Admission Indicator Code **(POADIND1-25)** | 25*1 | Claim Diagnosis E Code Diagnosis Present on Admission Indicator Code. (Refer to appendix table POADIND) |
| 488 | MEDPAR Diagnosis Code Count **(NUMDXCDE)** | 2 | The count of the number of diagnosis codes included in the stay. |
| 490 | MEDPAR Diagnosis **(DGN_CD1-DGN_CD25)** | 25*7 | The ICD-9-CM code identifying the primary condition or other coexisting conditions shown in the medical records as affecting the services provided during the beneficiary's stay. This element is part of the MEDPAR diagnosis group which may occur up to 25 times. |
| 665 | MEDPAR Surgical Procedure Indicator Switch **(SURGIND)** | 1 | The switch indicating whether or not there were any surgical procedures performed during the beneficiary's stay.<br><br>CODES:<br>0 = No surgery indicated<br>1 = Yes surgery indicated |
| 666 | MEDPAR Surgical Procedure Code Count **(NUMSRGCD)** | 2 | The count of the number of surgical procedure codes included in the stay. |
| 668 | MEDPAR Performed Date Count (1987+) **(NUMSRGDT)** | 2 | The count of the number of dates associated with the surgical procedures included in the stay. |
| 670 | MEDPAR Surgical Procedure Code 4*25 **(SRGCDE1-SRGCDE25)** | 100 | The ICD-9-CM code identifying the principal or other surgical procedure performed during the beneficiary's stay. |
| 770 | MEDPAR Surgical Procedure Performed Date 8*25 **(SG_M1-SG_M25, SG_D1-SG_D25, SG_Y1-SG_Y25)** | 200 | The date on which the ICD-9-CM surgical procedure was performed during the beneficiary's stay. MMDDYYYY |

| COL | FIELD | LENGTH | NOTES |
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| 970 | MEDPAR Blood Pints Furnished Quantity **(BLDPINTS)** | 4 | The quantity of blood (number of whole pints) furnished to the beneficiary during the stay. Note: this includes blood pints replaced as well as not replaced. |
| 974 | MEDPAR Beneficiary Identification Code **(OBIC)** | 2 | The BIC reported on the first claim record included in the stay, representing the values existing on the CWF beneficiary master record on the date the CWF host site processed the claim.<br>CODES: (Refer to appendix table BIC) |
| 976 | MEDPAR DRG Code **(DRGCODE)** | 3 | The code indicating the DRG to which the claims that comprise the stay belong for payment purposes. |
| 979 | MEDPAR Discharge Destination Code **(DISCDEST)** | 2 | The code primarily indicating the destination of the beneficiary upon discharge from a facility; also denotes death or SNF/still patient situations.<br>CODES: (Refer to appendix table STUS_CD) |
| 981 | MEDPAR DRG/Outlier Stay Code **(OUTLRCDE)** | 1 | The code identifying (1) for PPS providers if the stay has an unusually long length (day outlier) or high cost (cost outlier); or (2) for non-PPS providers the source for developing the DRG. |
| 982 | MEDPAR Beneficiary Primary Payer Code **(PRIMPAYR)** | 1 | The code indicating the type of payer who has primary responsibility for the payment of the Medicare beneficiary's claims related to the stay.<br><br>CODES:<br>A = Working aged bene/spouse with eghp<br>B = ESRD bene in 18-month coordination period with eghp<br>C = Conditional Medicare payment; future reimbursement expected<br>D = Auto no-fault or any liability insurance<br>E = Worker's compensation<br>F = Phs or other federal agency (other than dept of veterans affairs)<br>G = Working disabled<br>H = Black lung<br>I = Dept of veterans affairs<br>J = Any liability insurance<br>Z/BLANK = Medicare is primary payer |

| COL | FIELD | LENGTH | NOTES |
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| 983 | MEDPAR ESRD Condition Code (1987+) **(ESRDCOND)** | 2 | The code indicating if the beneficiary had an ESRD condition reported during the stay.<br>CODES:<br>00 = No ESRD Condition Codes<br>70 = Self-Administered Epo<br>71 = Full Care In Unit<br>72 = Self-Care In Unit<br>73 = Self-Care Training<br>74 = Home Dialysis<br>75 = Home Dialysis/100% Reimbursement<br>76 = Backup-In-Facility Dialysis |
| 985 | MEDPAR Source Inpatient Admission Code **(ADMSRCE)** | 1 | The code indicating the source of the beneficiary's admission to an Inpatient facility or, for newborn admission, the type of delivery.<br>CODES:<br>(Refer to Appendix table ADMSRCE) |
| 986 | MEDPAR Inpatient Admission Type Code **(ADMTYPE)** | 1 | The code indicating the type and priority of the beneficiary's admission to a facility for the Inpatient hospital stay.<br>CODES: (Refer to Appendix table ADMTYPE) |
| 987 | MEDPAR Fiscal Intermediary/Carrier Identification Number **(INTMNMBR)** | 5 | The identification of the intermediary processing the beneficiary's claims related to the stay.<br>NOTE: This field comes from the intermediary number that is present on the first claim record included in the stay. |
| 992 | MEDPAR Admitting Diagnosis Code (1987+) **(ADMDXCDE)** | 5 | The ICD-9-CM code indicating the beneficiary's initial diagnosis at the time of admission.<br>NOTE: This field comes from the admitting diagnosis code that is present on the last claim record included in the stay. |
| 997 | MEDPAR Admission Death Day Count (1987+) **(DEATHADM)** | 6 | The count of the number of days from the date the beneficiary was admitted to a facility to the beneficiary's date of death (DOD). |
| 1003 | Converted File Flag (1986) **(CONVERT)** | 1 | Blank = Not Converted<br>1 = Converted from length 330 to 1032 |

| COL | FIELD | LENGTH | NOTES |
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| 1004 | MEDPAR Warning Indicators Code (1987+) **(WARNINDC1-WARNINDC10)** | 10*1 | The codes (commonly called warning indicators) specifying detailed billing information obtained from the claims analyzed for the stay process. The purpose of these codes is to provide additional information for the MEDPAR user; i.e., let the user know whether or not the stay included adjustments, a single claim or multiple claims, any error conditions, etc.<br><br>CODES:<br>Warning indicator 1 ('adjustment indicator' Derived from the presence of query code values noted below on any of the claim records included in the analysis):<br>0 = No adjustment (no query code = 0 or 5<br>1 = Credit adjustment (query code = 0)<br>2 = Debit adjustment (query code = 5)<br>3 = Credit and debit adjustment (both query code = 0 and 5) |

| COL | FIELD | LENGTH | NOTES |
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| 1004 | MEDPAR Warning Indicators Code (1987+) **(WARNINDC1-WARNINDC10) (CONTINUED)** | 10*1 | Warning indicator 2 ('error condition' derived from checking the edit code trailer on the final action claims(s) that comprise the stay):<br>0 = No error<br>1 = Error condition<br><br>Warning indicator 3 ('reimbursement/total charge indicator' derived after summing up fields on The final action claim(s) that comprise the stay; checks resulting Medicare payment amount (commonly called reimbursement), total charge amount, as well as beneficiary primary payer amount and utilization day count):<br>0 = Medicare payment amount and total charge amount > zeroes<br>1 = Medicare payment amount and total charge amount < zeroes<br>2 = Medicare payment amount is a credit<br>3 = Total charge amount is a credit4 = Medicare payment amount, total charge amount, beneficiary primary payer claim payment amount, and utilization day count = zeroes<br><br>Warning indicator 4 ('utilization day/los day indicator' derived after summing up fields on the final action claim(s) that comprise the stay; compares resulting utilization day count and length-of-stay count): 0 = Utilization day count = los day count 1 = Utilization day count < los day count 2 = Utilization day count > los day count<br><br>Warning indicator 5 ('single/multiple claim indicator' derived when the stay record is created by checking the number of final action claims that comprise the stay):<br>0 = Stay includes a single final action claim<br>1 = Stay includes multiple final action claims<br>2 = Stay includes multiple final action claims and beneficiary is still a patient (applicable to SNF stays only) |

| COL | FIELD | LENGTH | NOTES |
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| | MEDPAR Warning Indicators Code (1987+) **(WARNINDC1-WARNINDC10) (CONTINUED)** | | Warning indicator 6 ('intermediary cancel indicator' derived from the presence of the values noted below for intermediary claim action code and intermediary-requested claim cancel reason code on any of the claims included in the analysis. If multiple claims contain these values, latest claim is used. If both specified action code and cancel reason code are present, cancel reason code takes priority.):<br>0 = No cancel action<br>1 = Cancel action by credit adjustment (action code = (2 or 6)<br>2 = Cancel action only (action code = 4)<br>3 = Coverage transfer (cancel reason code = C)<br>4 = Plan transfer (cancel reason code = P)<br>5 = Scramble (cancel reason code = S)<br>6 = Duplicate billing (cancel reason code = D)<br>7 = Other (cancel reason code = H)<br>8 = Combining 2 spells or 2 beneficiary records (cancel reason code = L)<br><br>Warning indicator 7 ('state/county numeric indicator' derived from checking the format of the beneficiary residence SSA state code and beneficiary residence county code on the final action claim(s) that comprise the stay; determine if in numeric range):<br>0 = State and county codes are valid numeric Values<br>1 = State and county codes are not in numeric range<br>2 = State code is not in numeric range 3 = County code is not in numeric range |

| COL | FIELD | LENGTH | NOTES |
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| | MEDPAR Warning Indicators Code (1987+) **(WARNINDC1-WARNINDC10) (CONTINUED)** | | Warning indicator 8 ('duplicate indicator' derived from the presence of two claim records with the same claim number, admission date, provider number, claim from/thru date, HCFA process date and query code; death/admission date indicator derived by comparing the admission date on the final claim(s) that comprise the stay to the beneficiary death date):<br>0 = Do duplicate record<br>1 = Duplicate record<br>2 = Death date < admission date<br>3 = Death date < admission date and duplicate record<br><br>Warning indicator 9 ('pass-thru indicator' derived from the presence of a pass thru per diem amount on the final action claim(s) that comprise the stay):<br>0 = No pass thru per diem present (Non-PPS)<br>1 = Pass thru per diem present on final action claims.<br><br>Warning indicator 10 (eff 3/96 update) (rugs Indicator applicable to 'nhcmq rugs III SNF demo' stay records derived from the presence of 9,000 series revenue center codes.)<br>0 = No rugs 9,000 series revenue center codes<br>2 = Rugs 9,000 series revenue center code(s) with service date 1/1/96 or later<br>3 = Rugs 9,000 series revenue center code(s) with service date 7/1/96 or later<br>4 = Rugs 9,000 series revenue center code(s) with service date 1/1/97 or later<br><br>Warning indicators 11 - 17 (not yet assigned; zeroes will be present) |
| 1022 | NPI Provider Number **(NPI_NUM)** | 10 | The NPI assigned to the institutional provider. The NPI may not be available prior to 7/1/2007. **Encrypted Data. * Special permission required to receive unencrypted data.** |
| 1032 | Filler | 1 | |