North Carolina Hospital Outpatient/Ambulatory Surgery Visit Data - Data Dictionary FY 2016

Alphabetic List of Variables and Attributes

Standard Research File

For a standard research file request one of three variables must be suppressed – diag1, fac, or ptzip
To discuss additional available variables, not included in standard research file, please contact project manager.

Variable	Type	Len	Label
admitdx	Char	7	REASON FOR VISIT DIAGNOSIS ICD-9-CM code or ICD-10-CM code. Decimal not included. Decimal implied between the 3rd and 4th digit
agem	Num	8	AGE IN MONTHS – Age in months for patients 31 days - 2 years old
agey	Num	8	AGE IN YEARS – Age in years for patients > 2 years old
asource	Char	1	ADMISSION SOURCE TYPE
			A = not newborn
			N = newborn
			X = unknown or not submitted
billtype	Char	4	BILL TYPE
			111 = Hospital Inpatient, Including Medicare Part A, original bill
			117 = Hospital Inpatient, Including Medicare Part A, replacement bill
			121 = Hospital Inpatient, Medicare Part B only, original bill
			127 = Hospital Inpatient, Medicare Part B only, replacement bill
			131 = Hospital Outpatient, original bill
			137 = Hospital Outpatient, replacement bill
			831 = Ambulatory Surgery Center, original bill
			837 = Ambulatory Surgery Center, replacement bill
			851 = Critical Access Hospital, original bill
			857 = Critical Access Hospital, replacement bill
birthwt	Num	8	BIRTH WEIGHT IN GRAMS
cpxcd1	Char	5	FIRST LISTED CPT-4 PROCEDURE CODE
cpxcd2-20	Char	5	CPT-4 PROCEDURE CODES 2-20 (see lookup for all included CPT-4 codes)
cpxday1	Num	8	DAYS FROM ENCOUNTER TO cpxcd1 – The number of days elapsed from the encounter date to the procedure date. A procedure can take place up to 2 days prior to the encounter date. Thus, this number can be negative. Zeros indicate the procedure is performed on the encounter date.
cpxday2-20	Num	8	DAYS FROM ENCOUNTER TO cpxcd2-20 – same as cpxday1
cpxmeth1-cpxmeth20	Num	8	Method of submission for cpxcd1-cpxcd20

dayscov	Num	8	DAYS COVERED – Encounter date minus discharge date. If encounter date equals discharge date, then length of stay = 1
diag1	Char	7	FIRST LISTED DIAGNOSIS CODE – ICD-9-CM code or ICD-10-CM code. Decimal not included. Decimal implied between the 3rd and 4th digit. (see lookup for all included diagnosis codes and diagnosis methods (ICD-9 or ICD-10))
diag2-diag25	Char	7	DIAGNOSIS CODES 2-25 (same as diag1)
dxrefmeth1-dxrefmeth25	Char	1	Method for diag1-diag25, 0=ICD-10-CM, 9=ICD-9-CM
erflag	Num	8	PRESENCE OF ED REV CODE (045x) = 1 – Patient admitted from ED to inpatient, Truven Derived Variable
ethnicity	Char	3	ETHNICITY – 1 = Non-Hispanic, 2 = Hispanic
fac	Char	11	FACILITY ID – Truven Hospital identification number (lookup contains facility name, address, and zip code)
fyear	Char	6	FISCAL YEAR – Four-digit fiscal year
orflag	Num	8	PRESENCE OF OR REV CODE (036x) = 1 – Indication of operating room use during stay, Truven Derived Variable
payer1	Char	5	PRIMARY PAYER CODE – State-specific payer code
			09 = Self Pay (historical P)
			10 = Central Certification (historical F)
			11 = Other Non-Federal Program (historical X)
			12 = Preferred Provider Organization (PPO) (historical Z)
			13 = Point of Service (POS) (historical Y)
			14 = Exclusive Provider Organization (EPO) (historical J)
			15 = Indemnity Insurance (historical L)
			16 = Health Maintenance Organization (HMO) Medicare Risk (historical K)
			AM = Automobile Medical (historical A)
			BL = Blue Cross & Blue Shield (historical B)
			CH = Champus (historical C)
			CI = Commercial Insurance (historical I)
			DS = Disability (historical G)
			HM = Health Maintenance Organization (HMO) (historical H)
			LI = Liability (historical Q)
			LM = Liability Medical (historical R)
			MA = Medicare Part A (historical M)
			MB = Medicare Part B (historical T)
			MC = Medicaid (historical D)
			(N = historical other government)

			OF = Other federal program (historical V)
			(S = historical self-insured)
			TV = Title V (historical 1)
			VA = Veteran Administration Plan (historical 2)
			WC = Workers Compensation Health Claim (historical W)
			ZZ = Mutually defined unknown (historical U)
payer2-3	Char	5	PAYER CODE 2-3 – secondary payer sources, same as payer1
paysub1-3	Char	4	PAYER SUBCLASS 1-3 – Payer sub-classification code (see lookup)
ptcnty	Char	3	PATIENT COUNTY – 3 digit FIPS COUNTY CODE
ptstate	Char	2	PATIENT STATE – State Abbreviation
ptzip	Char	5	5 DIGIT PATIENT ZIP CODE
race	Char	3	RACE
			1 = American Indian (historical 1)
			2 = Asian (historical 2)
			3 = Black or African-American (historical 3)
			4 = Native Hawaiian or Pacific Islander (historical 2)
			5 = Caucasian (historical 4)
			6 = Other race
			9 = Patient declined or unavailable
rehabflag	Char	1	Presence of Rehab Revenue Code (118, 128, 138, 148, 158), 1=Rehab revenue code present
revchg1	Num	8	ROUTINE CHARGES – Routine charges, sum of revenue codes 101, 110-179, 190-199, 670-679, 1001-1002
revchg2	Num	8	ICU/CCU CHARGES – ICU/CCU charges, sum of revenue codes 200-219
revchg3	Num	8	SURGERY CHARGES – Surgical charges, sum of revenue codes 360-379, 710-729
revchg4	Num	8	LAB CHARGES – Lab and blood charges, sum of revenue codes 300-319, 390-399, 740-759
revchg5	Num	8	PHARMACY CHARGES – Pharmacy charges, sum of revenue codes 250-269, 630-639
revchg6	Num	8	RADIOLOGY CHARGES – Radiology charges, sum of revenue codes 280-289, 320-359, 400-409
revchg7	Num	8	RESPIRATORY CHARGES – Respiratory charges, sum of revenue codes 410-419, 460-469
revchg8	Num	8	THERAPY CHARGES – Therapy charges, sum of revenue codes 420-449, 470-479, 2100-2109
revchg9	Num	8	SUPPLIES CHARGES – Supplies charges, sum of revenue codes 270-279, 620-629
revchg10	Num	8	OTHER CHARGES – Other charges, sum of revenue codes 70-77, 100, 180-189, 220-249, 290-299, 380-389, 450-459, 480-619, 640-669, 681-709, 730-739, 760-771, 780, 790-861, 880-929, 931-932, 940-949, 951-952, 960-999
sex	Char	1	SEX – F = FEMALE, M = MALE, U = UNKNOWN

source	Char	3	POINT OF ORIGIN (Related to Admission Source Type – asource – A = not newborn, N = newborn)
			1 = Non-health care facility point of origin (asource A only)
			2 = Clinic or physician's office (asource A only)
			4 = Transfer from a hospital (different facility) (asource A only)
			5 = Transfer from a skilled nursing facility (SNF), intermediate care facility (ICF), or assisted living facility (ALF) (asource A only)
			5 = Born inside this hospital (asource N only)
			6 = Transfer from another health care facility (asource A only)
			6 = Born outside this hospital (asource N only)
			8 = Court/law enforcement (asource A only)
			9 = Information not available (asource A only)
			D = Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer (asource A only)
			E = Transfer from ambulatory surgery center (asource A only)
			F = Transfer from a hospice facility (asource A only)
status	Char	6	PATIENT DISPOSITION – patient discharge status description (see lookup)
totchg	Num	8	TOTAL CHARGES – Total charges, actual submitted value
type	Char	3	ADMIT TYPE
			1 = Emergency
			2 = Urgent
			3 = Elective
			4 = Newborn
			5 = Trauma
			9 = Information not available