

**North Carolina Emergency Department Visit Data - Data Dictionary FY 2018**

**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
<b>admitdx</b>	Char	7	ADMITTING DIAGNOSIS OR REASON FOR VISIT ICD-9-CM code or ICD-10-CM code. Decimal not included. Decimal implied between the 3rd and 4th digit
<b>agem</b>	Num	8	AGE IN MONTHS – Age in months for patients 31 days - 2 years old
<b>agey</b>	Num	8	AGE IN YEARS – Age in years for patients > 2 years old
<b>asource</b>	Char	1	ADMISSION SOURCE TYPE A = not newborn N = newborn X = unknown or not submitted
<b>billtype</b>	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
<b>birthwt</b>	Num	8	BIRTH WEIGHT IN GRAMS
<b>cpxcd1</b>	Char	5	FIRST LISTED CPT-4 PROCEDURE CODE (In 2012 100% of procedures in NC ED were reported in CPT
<b>cpxcd2-20</b>	Char	5	CPT-4 PROCEDURE CODES 2-20 (see lookup for all included CPT-4 codes)
<b>cpyday1</b>	Num	8	DAYS FROM ENCOUNTER/ADMIT TO cpxcd1 – The number of days elapsed from the encounter/admission date to the procedure date. A procedure can take place up to 2 days prior to the encounter/admission date. Thus, this number can be negative. Zeros indicate the procedure is performed on the encounter/admission date.
<b>cpyday2-20</b>	Num	8	DAYS FROM ADMIT TO cpxcd2-20 – same as cpyday1
<b>cpymeth1-cpymeth20</b>	Num	8	Method of submission for cpxcd1-cpxcd20

<b>dayscov</b>	Num	8	DAYS COVERED – Encounter/Admission date minus discharge date. If encounter/admission date equals discharge date, then length of stay equals 1
<b>diag1</b>	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))
<b>diag2-dia25</b>	Char	7	DIAGNOSIS CODES 2-25 (same as diag1)
<b>dxrefmeth1-dxrefmeth25</b>	Char	1	Method for diag1-dia25, 0=ICD-10-CM, 9=ICD-9-CM
<b>erflag</b>	Num	8	PRESENCE OF ED REV CODE (045x) = 1 – Patient admitted from ED to inpatient
<b>ethnicity</b>	Char	3	ETHNICITY – 1 = Non-Hispanic, 2 = Hispanic
<b>fac</b>	Char	11	FACILITY ID – IBM Watson Health Hospital identification number (lookup contains facility name, address, city, state, zip code, and county)
<b>fyear</b>	Char	6	FISCAL YEAR – Four-digit fiscal year
<b>orflag</b>	Num	8	PRESENCE OF OR REV CODE (036x) = 1 – Indication of operating room use during stay
<b>payer1</b>	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)
<b>payer2-3</b>	Char	5	PAYER CODE 2-3 – secondary payer sources, same as payer1
<b>paysub1-3</b>	Char	4	PAYER SUBCLASS 1-3 – Payer sub-classification code (see lookup)
			Present on Admission Indicator (related to diag1-25) Y = Yes; present at time of inpatient admission N = No; not present at time of inpatient admission U = Unknown; documentation insufficient to determine if condition was POA W = Clinically undetermined; provider unable to determine clinically whether condition was POA or not
<b>poa1</b>	Char	1	1 = Exempt, This diagnosis
<b>poa2-25</b>	Char	1	Same as POA1
<b>ptcnty</b>	Char	3	PATIENT COUNTY – 3 digit FIPS COUNTY CODE
<b>ptstate</b>	Char	2	PATIENT STATE – State Abbreviation
<b>ptzip</b>	Char	5	5 DIGIT PATIENT ZIP CODE
<b>race</b>	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
<b>rehabflag</b>	Char	1	Presence of Rehab Revenue Code (118, 128, 138, 148, 158), 1=Rehab revenue code present
<b>revchg1</b>	Num	8	ROUTINE CHARGES – Routine charges, sum of revenue codes 101, 110-179, 190-199, 670-679, 1001-1002

<b>revchg2</b>	Num	8	ICU/CCU CHARGES – ICU/CCU charges, sum of revenue codes 200-219
<b>revchg3</b>	Num	8	SURGERY CHARGES – Surgical charges, sum of revenue codes 360-379, 710-729
<b>revchg4</b>	Num	8	LAB & BLOOD CHARGES – Lab and blood charges, sum of revenue codes 300-319, 390-399, 740-759
<b>revchg5</b>	Num	8	PHARMACY CHARGES – Pharmacy charges, sum of revenue codes 250-269, 630-639
<b>revchg6</b>	Num	8	RADIOLOGY CHARGES – Radiology charges, sum of revenue codes 280-289, 320-359, 400-409
<b>revchg7</b>	Num	8	RESPIRATORY CHARGES – Respiratory charges, sum of revenue codes 410-419, 460-469
<b>revchg8</b>	Num	8	THERAPY CHARGES – Therapy charges, sum of revenue codes 420-449, 470-479, 2100-2109
<b>revchg9</b>	Num	8	SUPPLIES CHARGES – Supplies charges, sum of revenue codes 270-279, 620-629
<b>revchg10</b>	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
<b>sex</b>	Char	1	SEX – F = FEMALE, M = MALE, U = UNKNOWN
<b>source</b>	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)
<b>status</b>	Char	6	PATIENT DISPOSITION - patient discharge status description (see lookup)
<b>totchg</b>	Num	8	TOTAL CHARGES – Total charges, actual submitted value
<b>type</b>	Char	3	ADMIT TYPE
			1 = Emergency
			2 = Urgent
			3 = Elective
			4 = Newborn

		5 = Trauma
		9 = Information not available