Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant:	**Wilton Pain Management Center, LLC d/b/a Wilton Surgery Center, LLC**
Docket Number:	**04-30251-CON**
Project Title:	**Expansion of Scope of Services**
Statutory Reference:	**Section 19a-638, Connecticut General Statutes**
Filing Date:	**April 23, 2004**
Decision Date:	**July 7, 2004**
Default Date:	**July 23, 2004**
Staff:	**Laurie Greci**

Project Description: Wilton Pain Management Center, LLC d/b/a Wilton Surgery Center, LLC ("Applicant") proposes to expand its scope of services from a licensed pain management center to an ambulatory surgery center that includes the performance of ophthalmic procedures. The Wilton Surgery Center ("Center") will be located at 195 Danbury Road in Wilton, Connecticut. The associated total capital expenditure is $449,000.

Nature of Proceedings: On April 23, 2004, the Office of Health Care Access ("OHCA") received the completed Certificate of Need ("CON") application of Wilton Pain Management Center, LLC d/b/a/ Wilton Surgery Center, LLC seeking authorization to expand the scope of its services to include ophthalmic surgical services. The Wilton Surgery Center ("Center") will be located at 195 Danbury Road in Wilton, Connecticut. The associated total capital expenditure is $449,000.

The Applicant is a health care facility or institution as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public was published in *The Hour* (Norwalk) on February 21, 2004. On May 18, 2004, OHCA received a request from Norwalk Hospital to hold a hearing concerning the Applicant's proposal. Pursuant to Section 19a-639, C.G.S., and as amended by Public Act 03-17, a public hearing regarding the CON application was held on June 8, 2004.

The Applicant was notified of the date, time and place of the hearing, and a notice to the public was published in *The Hour*. Commissioner Cristine A. Vogel served as Presiding Officer for this case. The public hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-639, C.G.S.

Norwalk Hospital petitioned for party status, or in the alternative, intervenor status with the right to cross-examine the Applicant, witnesses, and other participants. Norwalk Hospital was granted Intervenor status with full rights of cross-examination by the Presiding Officer.

The Presiding Officer heard testimony from the Applicant's and the Intervenor's witnesses and, in rendering this decision, considered the entire record of the proceeding. OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-639, C.G.S. The provisions of this section as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need
Impact on the Applicant's Current Utilization Statistics
Contribution of the Proposal to the Accessibility and Quality of Health Care Delivery in the Region

1. Wilton Pain Management Center, LLC ("Applicant") is a for-profit limited liability company organized to provide personalized, state-of-the-art quality interventional pain management. *(March 3, 2003, Docket Number 02-554 Final Decision, page 2)*

2. The Applicant was granted a Certificate of Need ("CON") under Docket Number 02-554 for the operation of a licensed surgical center ("Center") to provide interventional pain management services. Under Docket Number 03-22928-MDF the Applicant was authorized to change the location of the Center from 631-641 Danbury Road to 195 Danbury Road. The Center is currently in development and is scheduled to begin operations at 195 Danbury Road in December 2004. *(April 12, 2004, CON Application, page 1)*

3. The Applicant's proposed service area consists of the towns of New Canaan, Norwalk, Ridgefield, Weston, Westport, and Wilton. *(April 12, 2004, CON Application, page 8)*

4. Ophthalmologists ("Physician A " and "Physician B") within the service area contacted the Applicant inquiring about the availability of ambulatory ophthalmic surgical facilities at the Center. As the addition of ophthalmic services is consistent with the Center's long-range plan of providing a safe, convenient, and efficient environment for the provision of healthcare services, the Applicant proposes to include the service at the Center. *(April 12, 2004, CON Application, page 8)*

5. After initiation of the proposal the Applicant will change the name of the limited liability company to "Wilton Surgery Center, LLC". *(April 12, 2004, CON Application, page 13)*

6. Ophthalmologists are the only practitioners medically trained in the diagnosis, treatment, and prevention of medical disorders of the eye. The treatment modalities practiced by these specialists include surgical procedures. *(April 12, 2004, CON Application, pages 3 and 4)*

7. The addition of the ophthalmic procedures will enhance the Center's utilization at a minimum of cost due to the synergies shared with the pain management procedures. *(April 12, 2004, CON Application, page 1)*

8. The estimated population in the primary service area for 2000 is presented in the following table.

Table 1: Estimated Population in the Primary Service Area in 2000

Town	Total Population	Ages 35 to 44	Ages 45 to 64	Ages 65 and over
New Canaan	19,395	4,623	5,164	2,620
Norwalk	82,951	14,809	18,751	10,601
Ridgefield	23,643	3,540	6,506	2,583
Weston	10,037	1,987	2,903	969
Westport	25,749	4,905	7,216	3,883
Wilton	17,633	3,106	4,924	2,145
Total	**179,408**	**32,967**	**45,464**	**22,801**

(January 20, 2004, CON Application, page 60 and April 12, 2004, Completeness Response, Exhibit 1)

9. Cataract surgery will be the most commonly performed ophthalmic procedure at the Center. The following table lists the related CPT codes:

Table 2: Most Common Ophthalmic Procedures

CPT Code[1]	Description
66982	Cataract Surgery, Complex
66984	Extracap Extract Cataract Intraocular Lens
66821	YAG Laser Procedure

(April 12, 2004, CON Application, page 10)

[1] CPT Code is the "Current Procedural Terminology" code used to provide a uniform identification for medical purposes and billing purposes. CPT Coding is copyrighted by the American Medical Association.

10. The estimated annual procedure volume for the service area to receive cataract surgery with insertion of a prosthetic lens is 1,256. The following table summarizes the estimated demand:

Table 3: Estimated Annual Demand in Proposed Service Area

Description	Age Group		Total
	45 to 64	65 and older	
Population in Service Area	45,464	22,801	68,265
Incidence of Insertion of Prosthetic Lens per 10,000 persons[2]	51	449.1	
Estimated Annual Demand	232	1,024	**1,256**

(April 23, 2004, Completeness Response, Exhibit 1)

11. Physicians A and B will transfer their outpatient surgical procedures to the Center. A third ophthalmologist ("Physician C") that will join one of the practices will also perform procedures at the Center. The following projected procedure volume has been based on the most recent historical volume statistics for Physician A and B with the application of a 3% growth rate per year. The projected volume for Physician C has been based on the assumption that Physician C's practice will grow at a rate consistent with the practice growth rates for other ophthalmology practices in the area.

Table 4: Projected Procedure Volume

Description	Current	Year 1	Year 2	Year 3
Physician A	145	145	152	160
Physician B	250	250	263	276
Physician C	0	96	101	106
Increase	**-**	**96**	**121**	**146**
Total	**395**	**491**	**516**	**541**

(April 12, 2004, CON Application, page 10 and April 23, 2004, Completeness Response, Exhibit 1)

12. Two existing facilities within the proposed service area that are suitable for ophthalmic procedures are not available for use by the ophthalmologists. HealthSouth does not accommodate the procedures and Spector Eye Care Center, as a physician-owned facility, that does not make surgical time available to other ophthalmologists. *(April 12, 2004, CON Application, pages 9 and 10)*

13. Norwalk Hospital ("Hospital") has a single dedicated operating room for ophthalmic surgeries. The Applicant states that the approximate caseload for the Hospital in 2003 for the insertion of prosthetic lens was 850 cases. The total surgical caseload for the Hospital during 2003 was 10,592 procedures. *(April 23, 2004, Completeness Response, Exhibit 1)*

[2] National Hospital Discharge Survey and the National Survey of Ambulatory Surgery; numbers based on the International Classification of Diseases ("ICD-9-CM") Procedure Code 13.7.

14. Using the estimated annual demand of 1,256 procedures (Table 3) and subtracting the approximate caseload of 850 procedures at the Hospital in 2003, the excess demand over actual procedures is 406. *(April 12, 2004, Completeness Response, Exhibit 1)*

15. The Applicant asserts that the ophthalmologists that will be performing the procedures at the Center ("ophthalmologists") do not have adequate surgical time at the Hospital to cover the number of surgeries that they need to perform annually. *(April 12, 2004, CON Application, page 3)*

16. The need for the expansion of the scope of service at the Center is based on the lack of outpatient surgical facilities in the service area for ophthalmic surgical procedures, and the increasing demand for those procedures. *(April 12, 2004, CON Application, pages 3 and 4)*

17. One ophthalmologist ("Physician A") is scheduled to use a procedure room at the Hospital three days per month in a block of time that allows up to five surgeries. The average number of surgeries that the ophthalmologist has been able to perform in a month is 11 procedures. Another ophthalmologist ("Physician B"), in addition to the same procedure room schedule, is given a day on "stand-by". This ophthalmologist averages 17 cases per month. Physicians A and B ideally require enough surgical time for the performance of 33 cases per month. *(April 12, 2004, CON Application, page 3)*

18. Each ophthalmologist currently has surgical backlog of approximately 25 cases, which translates into a waiting time of 45 to 60 days. The waiting time will continue increasing after the addition of a new ophthalmologist to the practice. *(April 12, 2004, CON Application, pages 3 and 4)*

19. At the Hospital, due to the physicality of the procedure room's location, the turnaround time can be as long as 70 minutes. The Applicant stated that in a freestanding ambulatory surgery setting, turnaround time is approximately 30 minutes. *(April 12, 2004, CON Application, page 3)*

20. The Center will perform procedures on patients that fall into the American Society of Anesthesiologists ("ASA") status Classes I, II, and III. Normal, health patients are classified as Class I. Patients with mild systemic disease, such as diabetes controlled with oral medication or those with chronic bronchitis, fall into Class II. Class III patients are those with a more severe systemic disease, such as diabetes controlled with insulin, pulmonary insufficiency, immunosuppression, and coronary artery disease. *(April 12, 2004, CON Application, Exhibit 2, page 1-9)*

21. A history and physical exam must be performed on each patient prior to surgery. Those patients in Class III or patients with co-morbidities must have appropriate pre-operative testing performed within one week of the procedure. *(April 12, 2004, CON Application, Exhibit 2, page 1-9)*

22. Older patients have a harder time dealing with extended periods of fasting required by the use of conscious sedation. *(April 12, 2004, CON Application, page 3)*

23. Matthew Searles, a principal at Merritt Management Associates, LLC and a witness for the Applicant, testified that:
    - Physician A is granted three days per month of block time that allows for approximately six procedures per day;
    - Physician B is granted three days per month of block time that allows approximately five procedures per day; and
    - Vacation days, holidays and patient cancellations reduce the procedure time available to the physicians; and
    - The Applicant's estimated utilization of the dedicated procedure room was 96.9%.

    (June 3, 2004, Prefiled Testimony of Matthew Searles)

24. Jeffrey Oberman, M.D., testified at the hearing that as of May 24, 2004, he had a backlog of 25 patients waiting for ophthalmic procedures and that his next available procedure date was July 12th, a long wait period from both a patient convenience and a clinical standpoint. Dr. Oberman also testified that about 10% of all patients scheduled for a procedure cancel the appointment within a day or two of their scheduled time due to unexpected illness, which is common among the patient population of people 65 years of age and older. He also stated that it is difficult to reschedule that time because patients cannot be substituted at the last moment. *(June 3, 2004, Prefiled Testimony of Jeffrey Oberman, M.D.)*

25. Dr. Oberman testified to the Hospital's use of standby and first-come first served surgical times. He stated that standby time requires patients to come to the Hospital for a procedure with no set start time and that it can only be schedule with same day notice. Standby time also requires the surgeon to be at the Hospital waiting to perform the procedure. He also stated that first-come first-served time could only be booked with 5 days or less notice. First- come first-served times are generally in the afternoon. *(June 3, 2004, Prefiled Testimony of Jeffrey Oberman, M.D.)*

26. Dr. Oberman testified that staffing for ophthalmic procedures at the Hospital is inconsistent and staff trained for ophthalmic surgery are often not available. *(June 3, 2004, Prefiled Testimony of Jeffrey Oberman, M.D.)*

27. Leslie Doctor, M.D., testified at the hearing that in a hospital setting, it is impossible to have the depth of resources needed for every specialty to maximize efficiency. She believes that the sophistication of the ophthalmological procedures has outgrown the Hospital's current environment. She also testified that at a dedicated ophthalmology facility, the clinical changes would be easier to accomplish and it would enable physicians to keep up with the changes in standards of care. *(June 3, 2004, Prefiled Testimony of Leslie Doctor, M.D.)*

28. During the hearing, Paul Nurick, Chief Operating Officer at the Hospital testified that:
    - Total surgical case volume for 2003 approached 11,000 surgical cases;
    - The Hospital performed 7,119 ambulatory surgery procedures in FY 2003; and
    - Approximately 65% of all surgical procedures performed at the Hospital are performed on an ambulatory basis.

    (June 4, 2004, Prefiled Testimony of Paul Nurick)

29. Barbara Roof, Acting Vice President of Nursing and Patient Care Services and Executive Director of Surgical Services at the Hospital, testified that the ophthalmic service utilizes only 57% of the available time Monday through Friday. She testified that Paul Oberman, M.D., currently has a 92% utilization rate, the highest current rate by a physician that uses the room; Dr. Doctor's current utilization rate is 86%. Ms. Roof stated that Dr. Oberman and Dr. Doctor have not requested additional surgical time. *(June 4, 2004, Prefiled Testimony of Barbara Roof)*

30. Horace A. Laffaye, M.D., Chairman of Norwalk Hospital's Department of Surgery, stated that the ophthalmologists have block time available which has not been utilized. Once the physicians fill their blocks, they may schedule additional procedures using the first-come first-served blocks, which are elective bookings and guaranteed once booked. He also stated that these blocks follow the ophthalmology blocks two days per week. *(June 4, 2004, Prefiled Testimony of Horace A. Laffaye, M.D.)*

31. Under cross-examination, Dr. Oberman testified that his office first enters the surgeries into his office schedule and then his staff notifies the Hospital approximately eight days prior to the block date. He does not schedule procedures after 1 p.m. *(June 8, 2004, Cross-examination of Dr. Oberman)*

32. The Applicant will seek licensure from the State of Connecticut Department of Public Health as an Ambulatory Surgical Center. *(April 12, 2004, CON Application, page 7)*

33. The Applicant will also pursue accreditation with the American Academy of Pain Management and the American Association of Ambulatory Surgical Centers. *(November 21, 2002, CON Application for Docket Number 02-554, page 12)*

34. Section 19a-613 of the Connecticut General Statutes authorizes OHCA to collect patient-level outpatient data from health care facilities or institutions, as defined in Section 19a-630, C.G.S.

Financial Feasibility of the Proposal and its Impact on the Hospital's Rates and Financial Condition
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services

35. The proposal has a total capital expenditure of $449,000, which includes:

Table 5: Total Capital Expenditure

Component	Cost
Medical Equipment (Purchase)	$309,000
Construction/Renovation	140,000
Total Capital Expenditure	**$449,000**

(April 12, 2004, CON Application, page 14)

36. The total capital expenditure will allow the Applicant to fit out two additional operating rooms and purchase the medical equipment necessary to perform ophthalmological surgical procedures. *(April 12, 2004, CON Application, page 11)*

37. The source of funding for the project is member equity. *(April 12, 2004, CON Application, page 14)*

38. The Applicant projects that the proposal's incremental revenue over expense will be $116,313, $204,389, and $212,313 for FYs 2005, 2006, and 2007, respectively. *(April 12, 2004, CON Application, page 16)*

39. The Applicant's payer mix for the Center is presented below:

Table 6: Payer Mix

	Payer Mix in Percent (%)		
Source	**Pain Management**	**Ophthalmic**	**Combined**
Medicare	33%	80%	40.2%
Medicaid	0	5	0.8
Commercial Insurers	57	14	50.4
Self-Pay	2	0	1.7
Worker's Compensation	7	0	5.9
Uncompensated Care	1	1	1
Total	**100%**	**100%**	**100%**

(April 12, 2004, CON Application, page 16)

40. Patient co-payments for a procedure will be $300 lower at the Center than at a hospital-based setting; Medicare and third-party payers will also realize a savings. *(June 3, 2004, Prefiled Testimony of Matthew Searles)*

Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

The following findings are made based upon other principles and guidelines set forth in Section 19a-637, C.G.S.:

41. There is no State Health Plan in existence at this time. *(April 12, 2004, CON Application, page 3)*

42. The Applicant's proposal to enable the performance of ophthalmic surgical procedures at the Center will not result in any changes to the Applicant's teaching or research responsibilities. *(April 12, 2004, CON Application, page 13)*

43. The distinguishing characteristic of the Applicant's patient/physician mix is this will be the only facility in the area designed to meet the needs of both interventional pain management and ophthalmic surgeons and their patients. *(April 12, 2004, CON Application, page 13)*

44. The Applicant has sufficient technical and managerial competence to provide efficient and adequate service to the public. *(April 12, 2004, CON Application, page 12 and Exhibit III)*

Rationale

Wilton Pain Management Center, LLC ("Applicant") proposes to expand the scope of its services to include ophthalmic procedures. After being approached by ophthalmologists in the service area as to the availability of the facility for ophthalmological surgical procedures, the Applicant determined that the addition of ophthalmic services would complement the pain management procedures and be consistent with the Center's long-range plan of providing healthcare services. The Applicant proposes to add two operating rooms, procure the required medical equipment, and change the name of the limited liability company to "Wilton Surgery Center, LLC."

The Applicant determined that there is an unmet demand for over 400 ophthalmic surgical procedures in the proposed service area. Although the ophthalmologists that will perform their procedures at the Wilton Surgery Center ("Center") will be removing almost 400 cases from Norwalk Hospital ("Hospital"), the unmet demand and the growing use of ophthalmic surgery by the over 45 age group, will help offset the loss of the Hospital's volume.

The proposal is based on the Applicant's awareness of the need for outpatient facilities for the performance of ophthalmic surgical procedures in the service area. The only other provider of ophthalmic surgical services in the area is Norwalk Hospital ("Hospital"). The ophthalmologists that contacted the Applicant believe that there is inadequate operating room time available to them and their patients at the Hospital. The physicians' projected that the wait time for their patients that require an ophthalmological procedure, such as cataract removal, is approximately 45 to 60 days and increasing. The physicians believe that the wait time for their patients, most of them elderly and with poor sight, creates an undue burden on them and significantly impacts their quality of life.

Norwalk Hospital calculated the utilization rate of its dedicated ophthalmic surgery room at 57% for the first seven months of Fiscal Year ("FY") 2004. Testimony from the Applicant and the ophthalmologists disputed the Hospital's calculation, stating it was closer to 97%. The Hospital did verify that Dr. Oberman's and Dr. Doctor's current utilization of the room are 92% and 86%, respectively. The Hospital also testified that surgical time was available after 1 p.m. each day. The Applicants stated that their surgical patients are generally elderly and in less than good health. Surgery that late in the day is difficult for that population group as they are required to fast from the previous midnight until surgery and often have other health issues. The Hospital also testified that surgical time was available by using stand-by time or first-come first-served time; these are scheduled after the block times, which end at 1 p.m.

OHCA cannot independently verify numbers provided by either the Applicant or the Hospital and, therefore, unable to determine the utilization rate of the dedicated operating room. It is clear, however, that the additional surgery times available to the ophthalmologists are in the later part of the day. The late-day surgical time would make it necessary for the elderly, and usually co-morbid, patients to fast from midnight until after 1 p.m. Use of the Center for the performance of ophthalmic procedures will address the scheduled wait time, as well as the time of the day the patients receive their surgery.

Section 19a-613 of the Connecticut General Statutes authorizes OHCA to collect patient-level outpatient data from health care facilities or institutions. The submission of quarterly utilization reports to OHCA by the Applicant will provide OHCA with the data necessary to monitor the accessibility of care provided at the Center.

The proposal's total capital expenditure of $449,000 will be financed through member equity. The Applicant projects 491, 516, and 541 procedures to be performed by the ophthalmologists at the Center in 2005, 2006, and 2007, respectively. With approximately 3,400 people in the service area estimated to require ophthalmological surgery, this represents a 15% market share. The Applicant projects excess of revenues of $116,313, $204,389, and $212,313 for FYs 2005, 2006, and 2007, respectively. If volume projections are achieved, the Applicant's rates are sufficient to cover the proposed capital expenditure and operating costs associated with the project.

The number of procedures that will transfer to the Center is not a significant portion of the Hospital's ambulatory surgery volume. With an overall outpatient procedure volume of 7,119 at the Hospital in 2003, the number of ophthalmic procedures performed represented 5.5%. With the reduction in costs at an ambulatory facility, the patients, Medicare, and third-party payers will benefit by having the surgeries performed at the Center. The Applicant's projections are reasonable and the proposal is financially feasible and cost-effective.

Based on the foregoing Findings and Rationale, the Certificate of Need application of Wilton Pain Management, LLC to expand the scope of its services to include ophthalmic surgical procedures under the name "Wilton Surgery Center" at 195 Danbury Road in Wilton, Connecticut at a total proposed capital expenditure of $449,000, is hereby GRANTED.

Order

Wilton Pain Management, LLC d/b/a Wilton Surgery Center, LLC, located at 195 Danbury Road, Wilton, Connecticut, is hereby authorized to expand the scope of its services to include ophthalmic procedures, add two additional operating rooms, and purchase the medical equipment necessary to perform ophthalmological surgical procedures, at a total proposed capital expenditure of $449,000, subject to the following conditions:

1. This authorization shall expire July 7, 2005. Should the Applicant's project not be completed by that date, the Applicant must seek further approval from OHCA to complete the project beyond that date.

2. The Applicant shall not exceed the approved capital expenditure of $449,000. In the event that the Applicant learns of potential cost increases or expects that the final project costs will exceed those approved, the Applicant shall file with OHCA a request for approval of the revised project budget.

3. The Applicant shall limit the procedures to be performed at the Wilton Surgery Center to ophthalmic procedures and procedures in the field of pain management.

4. The Applicant will provide OHCA with utilization reports on a quarterly basis. The data elements and the format and submission requirements are described in Attachment 1.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Office of Health Care Access

July 7, 2004

Signed by Cristine A. Vogel
Commissioner

CAV/lkg

Attachment 1

Wilton Pain Management Center, LLC, d/b/a Wilton Surgery Center, LLC shall submit patient-specific data as listed and defined below for those patients that receive service, care, diagnosis or treatment at the Wilton Surgery Center. This information may be extracted from either the medical abstract or billing records or both and submitted to the Office of Health Care Access ("OHCA") in accordance with this Attachment.

I. The data are to be submitted in ASCII or Excel format on a computer disk.

II. Column headers to be used are listed below in field name after the name of each data element.

III. Data formats to be followed are listed for each data element.

IV. The disk or file should be clearly marked with the applicant's/facility's name, file name, docket number and its contents.

V. Accompanying the data submission, the applicant/facility must submit a full written description of the data submitted and its record layout.

VI. Initial data shall be submitted at the end of the first quarter in which the facility begins to provide the service for which it is licensed. Subsequent data for a calendar quarter shall be filed before the end of the calendar quarter following the calendar quarter in which the encounter was recorded. This data set shall contain the data records for each individual encounter from that facility during the preceding calendar quarter. For example, the data set to be filed before June 30, 2004, shall contain the data records for each individual encounter at that facility from January 1, 2004 until March 31, 2004.

VII. All data collected by OHCA will be subject to the laws and regulations of the State of Connecticut and the Office of Health Care Access regarding its collection, use, and confidentiality.

Outpatient Facility Encounter Data Layout
(For Institutions)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
1	Record Type Indicator: **01**	recid	Num(2)
2	Facility ID Code - The last four digits of the Medicare Provider Number for the unit from which the patient was discharged for the encounter being recorded.	facid	Char(4)
3	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. **Format: string (20, zero filled to left if fewer that 20 characters)**	mrn	Char(20)
4	Patient Control Number – unique number assigned by the facility to each patient's individual encounter that distinguishes the medical and billing records of the encounter. **Format: string (20, zero filled to left if fewer that 20 characters)**	patcont	Char(20)
5	Social Security Number – patient's SSN **Format: string (9, hyphens are implied). Blank if unknown**	ssn	Char(9)
6	Date of birth – the month, day, and year of birth of the patient whose encounter is being recorded. **Format: date (8, yyyy-mm-dd)**	dob	Date
7	Sex – patient's sex, to be numerically coded as follows: 1. Male = 1 2. Female = 2 3. Not determined = 3	sex	Char(1)
8	Race – patient-identified designation of a category from the following list, and coded as follows: A. White = 1 B. Black/African American = 2 C. American Indian/Alaska Native = 3 D. Native Hawaiian/Other Pacific Island = 4 (e.g., Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander.) E. Asian (e.g., Asian Indian, Chinese, Filipino, = 5 *Japanese, Korean, Vietnamese, other Asian)* *F. Two or more races = 6* *G. Some other race = 7* *H. Unknown = 8*	race	Char(1)
9	*Ethnicity – patient-identified ethnic origin from categories listed and coded as follows:* *A. Hispanic/Latino = 1* *(i.e., Mexican, Puerto Rican, Cuban or other Hispanic or Latino)* *B. Non-Hispanic/Latino = 2*	pat_eth	Char(1)
10	Patient's State – patient indicated state of primary residence.	patstate	Char(2)
11	Town – patient indicated town of primary residence.	twn_cty	Char(3)
12	Zip Code - zip code of the patient's primary residence	patzip	Char(5)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
13	**Relationship to Insured1 – means the patient's relationship to the identified insured or sponsor. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines:** (A) Patient is insured/Self = 01 (B) Spouse = 02 (C) Natural child/Insured financial responsibility = 03 (D) Natural child/Insured does not have financial responsibility = 04 (E) Step child = 05 (F) Foster child = 06 (G) Ward of the court = 07 (H) Employee = 08 (I) Unknown = 09 (J) Handicapped dependent = 10 (K) Organ donor = 11 (L) Cadaver donor = 12 (M) Grandchild = 13 (N) Niece/Nephew = 14 (O) Injured plaintiff = 15 (P) Sponsored dependent = 16 (Q) Minor dependent of a minor dependent = 17 (R) Parent = 18 (S) Grandparent = 19 (T) Life partner = 20	r_insure1	Char(3)
14	Employment status (e_stat) – means the patient's employment status. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines: (A) Employed full time = 1 (B) Employed part time = 2 (C) Not employed = 3 (D) Self employed = 4 (E) Retired = 5 (F) On active military duty = 6 (G) Unknown = 9	e_stat	Char(1)
15	Insured1's employer – means the name of the insured's employer. Blank if unknown or not applicable.	employ1	Char(50)
16	Insured1's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i1_state	Char (2)
17	Insured2's employer – means the name of the insured's employer. Blank if unknown or not applicable	employ2	Char (50)
18	Insured2's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i2_state	Char (2)
19	Insured3's employer – means the name of the insured's employer. Blank if unknown or not applicable.	employ3	Char (50)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
20	Insured3's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i3_state	Char (2)
21	Payment sources (Primary (ppayer), Secondary (spayer) and Tertiary (tpayer)) - the major payment sources that were expected at the time the dataset was completed, from the categories listed below: Self pay = A Worker's Compensation = B Medicare = C Medicaid = D Commercial Insurance Company = E Medicare Managed Care = F Medicaid Managed Care = G Commercial Insurance Managed Care = H CHAMPUS or TRICARE = I Other Government Payment = J Title V = Q No Charge or Free Care = R Other = M	ppayer	Char(1)
22	As defined in (19). Blank if not applicable.	spayer	Char(1)
23	As defined in (19). Blank if not applicable.	tpayer	Char(1)
24	Payer Identification (payer1, payer2, payer3) – the insured's payer (or National Plan ID) that identifies the payer organization from which the facility expects, at the time of the encounter, some payment for the bill. Up to three payer organizations shall be reported in the order of their expected contributions to the payment of the facility's bill. **Format: string (9, zero filled to left if fewer than 9 characters)**	payer1	Char(5)
25	As defined in (22). Blank if not applicable.	payer2	Char(5)
26	As defined in (22). Blank if not applicable.	payer3	Char(5)
27	Encounter type – indicates the priority of the encounter. Emergent = 1 Urgent = 2 Elective = 3	etype	Char(1)
28	Operating Physician – CT Provider ID identifying the provider who performed the service/treatment/procedure	ophysid	Char(7)
29	Attending Physician – CT Provider ID of the physician primarily responsible for the patient for this encounter.	pphysdocid	Char(7)
30	Charges – Total charges for this encounter **(Round the actual value contained on the discharge's bill to the nearest whole dollar amount, zero filled and right justified)**	chrg_tot	Num(8)
31	**Disposition – the circumstances of the patient's discharge. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines:**	pstat	Char(2)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
	Discharged to home or self care, (routine discharge) 01 Discharged or transferred to another short term general hospital for inpatient care 02 Discharged or transferred to a skilled nursing facility (SNF) 03 Discharged or transferred to an intermediate care facility (ICF) 04 Transferred to another type of institution for inpatient care 05 Discharged or transferred to a home under care of an organized home health service organization 06 Left or discontinued care against medical advice 07 **Discharged or transferred to home under the care of a home IV Provider** **08** Admitted as an inpatient to this hospital 09 Expired 20 Expired at home 40 Expired in a medical facility (e.g. hospital, SNF, ICF or free standing hospice) 41 Expired – place unknown 42 Hospice – home 50 Hospice – medical facility 51 Discharged or transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital 62 Discharged or transferred to Medicare certified long term care hospital (LTCH) 63 Discharged or transferred to a nursing facility certified under Medicaid but not certified under Medicare 64 Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 65		
32	Principal Diagnosis – the ICD-9-CM code for the condition which is established after the study to be chiefly responsible for the encounter being recorded. **Format: String (5, do not include decimal place -- decimal place is implied)**	dx1	Char(5)
33	Secondary Diagnoses (dx2 through dx10) – the ICD-9-CM codes for the conditions, exclusive to the principal diagnosis, which exist at the time the patient was treated or which developed subsequently to the treatment and which affect the patient's treatment for the encounter being recorded. Diagnoses which are associated with an earlier encounter and which have no bearing on the current encounter shall not be recorded as secondary diagnoses. **Format: String (5, do not include decimal place -- decimal place is implied)**	dx2	Char(5)
34	As defined in (31).	dx3	Char(5)
35	As defined in (31).	dx4	Char(5)
36	As defined in (31).	dx5	Char(5)
37	As defined in (31).	dx6	Char(5)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
38	As defined in (31).	dx7	Char(5)
39	As defined in (31).	dx8	Char(5)
40	As defined in (31).	dx9	Char(5)
41	As defined in (31).	dx10	Char(5)
42	E-code (ecode1 to ecode3) – The ICD-9-CM codes for external cause of injury, poisoning or adverse effect. **Format: string (5, do not include decimal place -- decimal place is implied)**	ecode1	Char(5)
43	As defined in (40).	ecode2	Char(5)
44	As defined in (40).	ecode3	Char(5)
45	Principal Procedure – the ICD-9-CM code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient. Blank if not applicable or not coded. **Format: String (4, do not include decimal place -- decimal place is implied)**	px1	Char(4)
46	Secondary Procedure (px2 through px10) – the ICD-9-CM codes for other procedures. Blank if not applicable or not coded. **Format: String (4, do not include decimal place -- decimal place is implied)**	px2	Char(4
47	As defined in (44).	px3	Char(4)
48	As defined in (44).	px4	Char(4)
49	As defined in (44).	px5	Char(4)
50	As defined in (44).	px6	Char(4)
51	As defined in (44).	px7	Char(4)
52	As defined in (44).	px8	Char(4)
53	As defined in (44).	px9	Char(4)
54	As defined in (44).	px10	Char(4)

	DATA RECORD TYPE 2		
	Description	**Field Name**	**Description**
1	Record Type Indicator: **02**	recid	Num(2)
2	Facility ID Code - The last four digits of the Medicare Provider Number for the unit from which the patient was discharged for the encounter being recorded.	facid	Char(4)
3	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. **Format: string (20, zero filled to left if fewer that 20 characters)**	mrn	Char(20)
4	Patient Control Number – unique number assigned by the facility to each patient's individual encounter that distinguishes the medical	patcont	Char(20)

	DATA RECORD TYPE 2		
	Description	**Field Name**	**Description**
	and billing records of the encounter. **Format: string (20, zero filled to left if fewer that 20 characters)**		
5	Social Security Number – patient's SSN **Format: string (9, hyphens are implied)**	ssn	Char(9)
6	Revenue Code - A UB-92 code that identifies a specific accommodation, ancillary service or billing calculation	rev	Char(4)
7	HCPCS Code – A uniform code used to report procedures, services and supplies for reimbursement. Blank if not applicable.	hcpc	Char(5)
8	First Modifier Code – means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod1	Char(2)
9	Second Modifier Code means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod2	Char(2)
10	Third Modifier Code – means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod3	Char(2)
11	Fourth Modifier Code means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod4	Char(2)
12	Units Of Service –number of days for multiple days or units of supply	units	Num (4)
13	Charges – charge for the listed service **(Round the actual value contained on the discharge's bill to the nearest whole dollar amount, zero filled and right justified)**	chrg	Num (6)
14	Service Date – The month, day, and year for each procedure, service or supply. **Format: date (8, yyyy-mm-dd)**	servdate	Date

*** Multiple rows of Data Record Type 2 will be needed to report all HCPCS/CPT and revenue codes recorded for an encounter; however there should be only unique occurrences of combinations of revenue and HCPCS codes and of revenue codes (if no HCPCS code is assigned) for an encounter.**