Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **Evergreen Endoscopy Center, LLC**

Docket Number: **06-30739-CON**

Project Title: **Establish and Operate Evergreen Endoscopy Center**

Statutory Reference: **Sections 19a-638, Connecticut General Statutes**

Filing Date: **October 12, 2006**

Decision Date: **January 9, 2007**

Default Date: **January 10, 2007**

Staff: **Laurie K. Greci**

Project Description: Evergreen Endoscopy Center, LLC ("Applicant") proposes to establish and operate a freestanding endoscopy center at Evergreen Walk on Tamarack Avenue, South Windsor, Connecticut, at a total capital cost of $2,583,065.

Nature of Proceeding: On October 12, 2006, the Office of Health Care Access ("OHCA") received the Applicant's Certificate of Need ("CON") application seeking authorization to establish and operate a freestanding endoscopy center to be located at Evergreen Walk, South Windsor, Connecticut, at a total capital cost of $2,583,065. The Applicant is a health care facility or institution as defined by Section 19a-630, of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 19a-638, C.G.S., a notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent was published in *The Journal Inquirer* (Manchester) on May 5, 2006. Pursuant to Public Act 05-75, three individuals or an individual representing an entity with five or more people had until November 2, 2006, the twenty-first calendar day following

the filing of the Applicant's CON application, to request that OHCA hold a public hearing on the Applicant's proposal. OHCA received no hearing requests from the public.

OHCA's authority to review and approve, modify or deny this application is established by Section 19a-638, 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
Contribution of the Proposal to the Quality and Accessibility of Health Care Delivery in the Region
Impact on the Applicant's Current Utilization Statistics

1. Evergreen Endoscopy Center, LLC ("Applicant" or "EEC"), a newly formed limited liability company, proposes to establish and operate Evergreen Endoscopy Center, a for-profit freestanding endoscopy[1] center ("Center") in a medical office building to be constructed at Evergreen Walk, Tamarack Avenue, South Windsor, Connecticut. The physicians will offer services for all gastrointestinal and liver diseases, including screening, diagnosis, and treatment. There will be a special interest in colon cancer screening.[2,3] *(August 25, 2006, Initial CON Submission, page 2)*

2. The Center will be constructed in a new medical office facility. The Center will have four procedure rooms, twelve pre/post-procedure areas, and four step-down chairs. One of the pre/post-procedure areas has been designed to accommodate patients requiring isolation. *(August 25, 2006, Initial CON Submission, page 24)*

3. The Eastern Connecticut Health Network ("ECHN") holds 50% interest in the EEC and the eight physicians associated with the proposal ("physicians") also hold 50% of the EEC. *(August 25, 2006, Initial CON Submission, page 3)*

4. ECHN is the parent company for Manchester Memorial Hospital ("MMH") in Manchester and Rockville General Hospital ("RGH") in Vernon. The physicians involved in the proposal all have active privileges at ECHN and will remain on staff at MMH and RGH. *(August 25, 2006, Initial CON Submission, page 3)*

5. The Operating Agreement of the EEC requires that ECHN will own no fewer than 250 Class A Units of ownership interest ("Units") in the EEC. Physicians may purchase up to 250 Class B Units. Economic interest in the EEC will be allocated among the members of the EEC pro rata in proportion to the number of Units held. In addition to the other items

[1] Endoscopy within this decision refers to any procedure that involves the examination of the interior of a hollow organ or part (such as the colon or esophagus) for diagnostic or therapeutic purposes, usually requiring the use of a fiber-optic flexible or rigid tubular instrument for visualization.
[2] Medicare provides coverage of a screening colonoscopy for beneficiaries age 50 or older based on risk.
[3] The American Gastroenterology Association states that colonoscopy is the preferred test for colon cancer for patients who have tested positive on other screening procedures and for patients with a family history of nonpolyposis colorectal cancer; screening may be done at two or five year intervals.

listed in the Operating Agreement of the EEC, the approval of the Class A member and the majority of the Class B members is required to:

a. Sell, pledge of other wise dispose of all or substantially all of the assets of the EEC;
b. Merge of consolidate with another Person;
c. Amend the Articles of Organization or the Operating Agreement;
d. Dissolve, liquidation or wind up the EEC; and
e. Admit any Person as Member.

(August 25, 2006, Initial CON Submission, pages 791,796, 797, and 800)

6. Class B Members of the EEC must be a qualified colorectal surgeon or gastroenterologist in the ECHN service area. *(August 25, 2006, Initial CON Submission, page 821)*

7. ECHN has the right and the authority to cause the EEC to carry out the charitable purposes of ECHN and its two hospitals, and to refrain from any act or activity inconsistent with the tax-exempt status of ECHN. *(August 25, 2006, Initial CON Submission, page 793)*

8. The Applicant based the need for the Center on the following:
   a. The large volume of procedures performed by the eight physician/owners and the expected growth of their practices;
   b. Accessibility of a freestanding facility for patients and the suitability of a freestanding ambulatory setting for screening patients; and
   c. The recruitment efforts of MMH and independent ECHN physicians' practices to attract gastroenterologists and colorectal surgeons.

   (August 25, 2006, Initial CON Submission, page 3)

9. The Center's proposed service area is comprised of the following towns:

Table 1: Proposed Service Area

Service Area	Towns
Primary	Andover, Ashford, Bolton, Coventry, East Windsor, Ellington, Manchester, South Windsor, Tolland, Vernon, and Willington
Secondary	Columbia, East Hartford, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union

(October 12, 2006, Completeness Response, page 1)

10. The following table reports the number of outpatient endoscopic procedures by fiscal year ("FY") for each of the physicians practicing gastroenterology at ECHN. The procedures were performed at MMH or RGH:

Table 2: Outpatient Endoscopic Procedures Performed at MMH or RGH

Physician[4]	Specialty	FY 2003	FY 2004	FY 2005
A	Gastroenterology	224	1,248	1,402
B	Gastroenterology	3,004	3,578	3,332
C	Colorectal	301	288	288
D	Colorectal	324	352	422
E	Gastroenterology	1,243	1,038	1,513
F	Colorectal	323	308	235
G	Gastroenterology	1,193	1,103	1,173
H	Colorectal	336	326	361
I	Gastroenterology	1,788	1,816	1,987
J	Gastroenterology	1,943	1,930	2,096
K	Gastroenterology	1,161	1,211	1,309
L	Colorectal	128	126	106
M	General Surgery	61	12	60
N	Gastroenterology	81	57	38
O	Gastroenterology	0	0	27
P	Gastroenterology	636	241	0
Total Outpatient Procedures		**12,746**	**13,634**	**14,349**

(January 4, 2007, Supplemental Information received by e-mail)

[4] The physicians involved in the proposal are identified as Physicians A through H. Physicians I, J, K, L, and M will be remaining at ECHN. Physician P retired in 2004, and Physician N retired in 2005. Physician O, new to the staff in 2005, only performed 35 procedures and has since moved out-of-state.
Note: The information provided by the Applicant in Table 2 cannot be verified by OHCA.

11. The following table reports the number of the fourteen (14) most commonly performed endoscopic procedures (such as esophagoscopy, esophagogastrodudodenoscopy, colonoscopy, flexible sigmoidoscopy, and proctosigmoidoscopy) for each of the physicians that is involved in the proposal.

Table 3: Summary of Commonly Performed Endoscopic Procedures by Physician

Physician	FY 2003	FY 2004	FY 2005
A	223	1,204	1372
B	2,588	3,122	2833
C	313	281	290
D	321	361	415
E	1,264	1,121	1528
F	325	300	236
G	1,159	1,026	1082
H	333	327	358
Total	**6,526**	**7,742**	**8,114**

Note: The information provided by the Applicant cannot be verified by OHCA.
(August 25, 2006, Initial CON Submission, pages 6, 7, and 8)

12. The projected numbers of procedures by physician to be performed in the first three years at the Center are given in the following table. The projected endoscopic procedure volume includes those of a new physician that the Center's physicians will be recruiting for their practice.

Table 4: EEC's Projected Number of Endoscopic Procedures

Physician	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
A	1,358	1,404	1,452	1,558	1,679
B	2,716	2,808	2,904	3,119	3,365
C	387	400	413	439	469
D	556	575	594	632	674
E	1,546	1,509	1,653	1,772	1,908
F	298	308	319	339	363
G	1,136	1,175	1,215	1,301	1,399
H	497	513	531	564	601
Subtotal	8,494	8,783	9,082	9,725	10,456
80% of Subtotal	6,795	7,026	7,265	7,847	8,514
EEC Recruited Physician	n/a	n/a	299	597	896
Total No. of Procedures Projected to be Performed at the Center	n/a	n/a	**7,564**	**8,445**	**9,410**

Note: The Applicant stated that the ECHN and the American Cancer Society have been providing educational sessions and materials concerning colon cancer to the community and primary care physicians. It is expected that these programs will increase the number of persons receiving a screening colonoscopy. The growth rate for endoscopic procedures at the two hospitals, MMH and RGH, has historically been 3.4%.
Note: OHCA cannot verify the Applicant's projections.
(August 25, 2006, Initial CON Submission, page 8 and October 12, 2006, Completeness Response, pages 3 and 4)

13. The Applicant stated that the physicians and the recruited gastroenterologist intend to move 80% of their procedure volume to the Center and the remaining 20% will be performed at MMH or RGH. *(August 25, 2006, Initial CON Submission, pages 7 and 8)*

14. The Applicant stated that Physicians I. J, K, L, and M are not involved with the Center. These physicians are projected to provide 5,900 procedures in 2008. Combined with the 1,800 procedures that the Center's physicians will perform at MMH or RGH and 1,900 procedures projected to be performed by new recruits to replace Physicians N and P who retired, 9,600 procedures will be performed at ECHN in FY 2008. Note: OHCA cannot verify the Applicant's projections. *(August 25, 2006, Initial CON Submission, pages 8 and 11 and October 12, 2006, Completeness Response, page 4)*

15. With seven to eight physicians continuing to perform their procedures at the hospitals and the eight EEC physicians continuing to perform approximately 20% of their procedures at MMG and RGH, the Applicant stated that half of the existing volume will remain in the hospitals. *(August 25, 2006, Initial CON Submission, page 11)*

16. EEC proposes to be accredited by the Accreditation Association for Ambulatory Health Care and will follow the Standard Practice Guidelines of the American Gastroenterology Association. Jeffrey Breiter, M.D. will serve as the Center's Medical Director. *(August 25, 2006, Initial CON Submission, page 18 and October 12, 2006, Completeness Submission, page 11)*

17. The hours of operation for the proposed Center will be Monday through Friday from 7:00 a.m. to 5:00 p.m. *(August 25, 2006, Initial CON Submission, page 14)*

18. 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.

Financial Feasibility of the Proposal and its Impact on the Applicant's Rates and Financial Condition
Rates Sufficient to Cover Proposed Capital and Operating Costs
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Consideration of Other 19a-637, C.G.S. Principles and Guidelines

19. The total capital cost for the proposal is $2,583,065 includes the following components:

Table 5: Capital Expenditure Components

Item	Cost
Construction/Renovation	$ 763,435*
Medical Equipment (Purchase)	571,148
Non-Medical Equipment (Purchase)	42,100
Start-up Costs	
Total Capital Expenditure	**$1,843,709**
Leased Medical Equipment, fair market value	739,356
Total Capital Cost	**$2,583,065**
Capitalized Financing Costs	665,537**
Total Capital Costs, including Capitalized Financing Cost	**$3,248,602**

* Total cost of $1,348,435 less tenant improvements of $585,000 which is included in the base leasing fee.
** Informational purposes only.
(August 25, 2006, Initial CON Submission, page 24)

20. The funding sources for the proposal are $580,274 of EEC's equity, a 10-year conventional loan of $1,263,435, and 10-year lease financing of $739,356. *(August 25, 2006, Initial CON Submission, page 27)*

21. The construction costs consist of the following:

Table 6: Construction Cost Breakdown

Item	Cost
Building Work	$1,142,000
Architectural and Engineering	122,585
Contingency	52,850
Inflation Adjustment	31,000
Subtotal	**$1,348,435**
Tenant Improvements Allowance	585,000
Total	**$ 763,435**

(August 25, 2006, Initial CON Submission, pages 24 and 25)

22. Construction of the Center is scheduled to begin in May 2007, with licensure by the State of Connecticut Department of Public Health and commencement of operations to occur in July 2008. *(August 25, 2006, Initial CON Submission, page 25)*

23. The Applicant is projecting the following incremental revenues and expenses for the first three years of the project:

Table 7: Projected Incremental Revenues and Expenses

Description	**FY 2008**	**FY 2009**	**FY 2010**
Revenue from Operations	$4,322,764	$4,826,248	$5,377,738
Expenses			
Salaries and Fringe Benefit	1,190,640	1,293,271	1,418,163
Professional Services	151,280	168,900	188,200
Supplies and Drugs	453,840	506,700	564,600
Lease	322,245	324,740	335,917
Bad Debt	64,841	72,394	80,666
Depreciation/Amortization	160,837	321,674	321,674
Interest Expense	113,589	106,314	98,415
Other	155,000	160,000	165,000
Gain from Operations	**$1,710,491**	**$1,872,256**	**$2,205,103**

(November 17, 2006, Supplemental Submission by electronic mail, Revised Pro Forma)

24. ECHN projects that the shift of hospital volume to the Center will result in incremental losses of $439,264, $426,249, and $331,463 for FYs 2008, 2009, 2010, respectively. While ECHN will lose money initially from the drop in volume of procedures performed at MMH and RGH, ECHN will realize $855,245, $936,128, and $1,102,551, for FYs 2008, 2009, and 2010, respectively, from the Center's gains from operations. The incremental losses to ECHN decrease over the first three years of the proposal and the Applicant stated that the impact on the hospitals will break even by the seventh year. *(August 25, 2006, Initial CON Submission, pages 14 and 29)*

25. ECHN projects that with the proposal it will realize net revenues of $1,409,950, $1,555,651 and $1,793,895 in FYs 2008, 2009, and 2010, respectively. *(August 25, 2006, Initial CON Submission, page 762)*

26. The projected payer mix for the Center is presented in the following table:

Table 8: EEC Projected Payer Mix

Payer	Payer Percent (%)		
	FY 2008	**FY 2009**	**FY 2010**
Medicare	38.5	38.5	38.5
Medicaid	6.9	6.9	6.9
TriCare (CHAMPUS)	0.3	0.3	0.3
Total Government	45.7	45.7	45.7
Commercial Insurers	52.9	52.9	52.9
Uninsured	1.4	1.4	1.4
Workers Compensation	0	0	0
Total Non-Government	54.3	54.3	54.3
Total Payer Mix	**100**	**100**	**100**

(August 25, 2006, Initial CON Submission, page 28)

27. There is no State Health Plan in existence at this time. *(August 25, 2006, Initial CON Submission, page 2)*

28. The Applicant has adduced evidence that this proposal is consistent with the long-range plan of Evergreen Endoscopy Center, LLC to establish the Center. *(August 25, 2006, Initial CON Submission, page 2)*

29. The Applicant stated that it has not undertaken any activities to improve productivity and contain costs. *(August 25, 2006, Initial CON Submission, page 20)*

30. The Applicant does not have any teaching or research responsibilities. *(August 25, 2006, Initial CON Submission, page 20)*

31. There are no distinguishing characteristics of the Applicant's patient/physician mix. *(August 25, 2006, Initial CON Submission, page 21)*

32. The Applicant has provided evidence that it has technical, financial, and managerial competence. *(August 25, 2006, Initial CON Submission, Exhibit 25)*

33. The Applicant's rates are sufficient to cover the proposed capital and operating costs associated with the proposal. *(August 25, 2006, Initial CON Submission, Exhibit 29)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of an existing service, the specific type of service proposed to be offered, the current utilization of the service and the financial feasibility of the proposal.

Evergreen Endoscopy Center, LLC ("Applicant" or "EEC") proposes to establish a single-specialty, outpatient endoscopy center ("Center") at Evergreen Walk on Tamarack Avenue in South Windsor, Connecticut. The Applicant is a newly formed limited liability company. The Eastern Connecticut Health Network ("ECHN") holds 50% interest in the EEC and the eight physicians associated with the proposal ("physicians") also hold 50% of the EEC. The Center will have four procedure rooms, twelve pre/post-procedure areas, and four step-down chairs. The Center's physicians will offer services for all gastrointestinal and liver diseases, including screening, diagnosis, and treatment. The establishment of the Center will allow the physicians to offer to patients a non-hospital, freestanding facility in which to receive an endoscopic procedure.

The Applicant stated that there is an increasing demand for endoscopic procedures as demonstrated by the volume of procedures performed by the Center's physicians from Fiscal Year ("FY") 2003 to FY 2005. The total number of outpatient endoscopic procedures performed at ECHN's two hospitals were 12,746, 13,634, and 14,349 procedures in FYs 2003, 2004, and 2005, respectively, for an overall two-year increase of 12.6%. In FYs 2003, 2004, and 2005, the Center's physicians performed 6,526, 7,742, and 8,114 endoscopic procedures, respectively, of the types of procedures that will be performed at the new Center. The increase in patient demand for endoscopy procedures over the past several years has been due, in part, to the colonoscopy being the preferred screening tool for colon cancer. The demand for colonoscopies and other endoscopic cancer screening procedures is projected to further increase due to the larger numbers of persons requiring it and the educational and outreach efforts of ECHN. OHCA recognizes that with the Applicant's established referral patient base, the proposed outpatient endoscopy center will allow the Center's physicians to provide endoscopic services in a setting that will improve the quality and accessibility of health care delivery in the region. Section 19a-613, C.G.S. 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 proposed facility.

Commencement of operations at the Center will initially decrease the procedure volume at ECHN's two hospitals. ECHN has recruited two physicians to replace those that retired. With the additional physicians, the increasing demand in endoscopic procedures, and the performance of 20% of the Center's physicians' procedures at ECHN, the number of procedures to be performed at the two hospitals will increase relative to the number of procedures that will remain.

The proposal is financially feasible. The project has a total capital cost of $2,583,065. Funding will be provided by a combination of the Applicant's equity and conventional loan. The Applicant projects a gain from operations of operation of $1,710,491, $1,872,256, and $2,205,103, for FYs 2008, 2009, and 2010, respectively. Through its owner-membership in the Center, ECHN will receive 50% of these gains, helping to offset the loss of volume in the initial years of the Center's operations. Although OHCA cannot draw any conclusions based on the financial information provided, the Applicant's projections appear reasonable and achievable.

Based upon the foregoing Findings of Fact and Rationale, the Certificate of Need request of Evergreen Endoscopy Center, LLC for the establishment of a single-specialty, outpatient endoscopy center to be located at Evergreen Walk on Tamarack Avenue in South Windsor, Connecticut, at a total capital cost of $2,583,065 is hereby GRANTED, subject to conditions.

Order

Evergreen Endoscopy Center, LLC ("Applicant") is hereby authorized to establish and operate a single-specialty, outpatient endoscopy center to be located at Evergreen Walk on Tamarack Avenue in South Windsor, Connecticut, at a total capital cost of $2,583,065. The authorization is subject to the following conditions:

1. This authorization expires on January 8, 2009. 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 report to OHCA, in writing, the date of the commencement of operations at Evergreen Endoscopy Center to OHCA within 30 days of the commencement date.

3. The Applicant shall not exceed the approved capital cost of $2,583,065. 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.

4. Should the Applicant intend or plan any change in the scope or location of the outpatient endoscopy center in South Windsor, Connecticut, the Applicant shall file with OHCA a Certificate of Need, Determination Request, or Letter of Intent regarding the intended or planned service change or location.

5. All physicians who perform procedures at the outpatient endoscopy center shall be members or employees of Evergreen Endoscopy Center, LLC.

6. The ownership interest of Eastern Connecticut Health Network shall not fall below 50%.

7. If Evergreen Endoscopy Center, LLC proposes in the future to permit non-members to use the facility, or change the ownership interests of ECHN prior OHCA approval will be required.

8. Evergreen Endoscopy Center, LLC shall provide OHCA with utilization reports on a quarterly basis. The data elements and the format and submission requirements are described in Attachment 1. The Applicant shall include in the quarterly report the name and telephone number of the person that OHCA may contact for data inquiries. In addition to basic data analyses, OHCA will use the submitted data to assure that residents of the greater South Windsor area have appropriate access to the site.

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

January 9, 2007

Signed by Cristine A. Vogel
Commissioner

CAV:lkg

Attachment 1

Evergreen Endoscopy Center, LLC shall submit patient-specific data as listed and defined below for those patients that receive service, care, diagnosis or treatment at the Central Connecticut Endoscopy 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 Professionals)

#	Description	Field Name	Data Type	Start	Stop
1	Facility ID -CMS assigned National Provider Identifier (effective May 23, 2005) or OHCA assigned SID # or 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(10)	1	10
2	Fiscal Year – Hospital fiscal year runs from October 1 of a calendar year to September 30 of the following calendar year and is the year of discharge.	fy	Char(4)	11	12
3	Quarter – The quarter of discharge. January 1 – March 31 - 2 April 1 – June 30 - 3 July 1 - September 30 - 4 October 1 – December 31 - 1	quart	Char(1)	13	13
4	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)	14	33
5	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)	34	53
6	Social Security Number – patient's SSN **Format: string (9, exclude hyphens)**	ssn	Char(9)	54	62
7	Date of birth – the month, day, and year of birth of the patient whose encounter is being recorded. **Format: date (8, mmddyyyy)**	dob	Date	63	70
8	Sex – patient's sex, to be numerically coded as follows: 1. Male = 1 2. Female = 2 3. Not determined = 3	sex	Char(1)	71	71

9	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 = 5 (e.g., Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, other Asian) F. Two or more races = 6 G. Some other race = 7 H. Unknown = 8	race	Char(1)	72	72
10	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)	73	73
11	Patient's State – patient indicated state of primary residence.	patstate	Char(2)	74	75
12	Town – patient indicated town of primary residence.	twn_cty	Char(3)	76	78
13	Zip Code – zip code of the patient's primary residence	patzip	Char(5)	79	83
14	Relationship to Insured1 – means the categories of patient's relationship to the identified insured or sponsor as listed below: 1. Self = 1 2. Spouse = 2 3. Child = 3 4. Other = 4	r_insure1	Char(3)	84	86
15	Employment status (e_stat) – means the categories of patient's employment status as listed below: 1. Employed = 1 2. Full-time student = 2 3. Part-time student = 3 4. Retired = 4 5. Other = 5	e-stat	Char(1)	87	87
16	Insured1's employer – means the name of the insured's employer.	employ1	Char(50)	88	137
17	Insured1's state of residence – means the insured's state of primary residence.	i1_state	Char (2)	138	139

18	Insured2's employer – means the name of the insured's employer.	employ2	Char (50)	140	189
19	Insured2's state of residence – means the insured's state of primary residence.	i2_state	Char (2)	190	191
20	Insured3's employer – means the name of the insured's employer.	employ3	Char (50)	192	241
21	Insured3's state of residence – means the insured's state of primary residence.	i3_state	Char (2)	242	243
22	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)	244	248
23	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)	249	253
24	As defined in (23)	dx3	Char(5)	254	258
25	As defined in (23)	dx4	Char(5)	259	263
26	As defined in (23)	dx5	Char(5)	264	268
27	As defined in (23)	dx6	Char(5)	269	273
28	As defined in (23)	dx7	Char(5)	274	278
29	As defined in (23)	dx8	Char(5)	279	283
30	As defined in (23)	dx9	Char(5)	284	288
31	As defined in (23)	dx10	Char(5)	289	293
32	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)	294	298
33	As defined in (32)	ecode2	Char(5)	299	303
34	As defined in (32)	ecode3	Char(5)	304	308
35	Date of service– the month, day, and year for each procedure, service or supply. "To (dost) & From (dosf)" are for a series of identical services provider recorded.	dosf	Date	309	316

	Format: date (8, mmddyyyy)				
36	As defined in (35)	dost	Date	317	324
37	Principal Procedure - the HCPCS/CPT code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient.	px1	Char(5)	325	329
38	Modifier (mod1 & mod2) – 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.	mod1	Char(2)	330	331
39	As defined in (38)	mod2	Char(2)	332	333
40	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum1	Char(2)	334	335
41	Units of services – number of days for multiple days or units of supply.	Units1	Num (4)	336	339
42	Charge – charge for the listed service	Charge1	Num (6)	340	345
43	Secondary Procedure (px2 through px10) – the HCPCS/CPT codes for other significant procedures.	Px2	Char(5)	346	350
44	Modifier (mod3 & mod4) – 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.	mod3	Char(2)	351	352
45	As defined in (38)	mod4	Char(2)	353	354
46	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum2	Char(2)	355	356
47	Units of services – number of days for multiple days or units of supply.	Units2	Num (4)	357	360
48	Charge – charge for the listed service.	Charge2	Num (6)	361	366
49	As defined in (43)	px3	Char(5)	367	371
50	Modifier (mod5 & mod6) – 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.	mod5	Char(2)	372	373
51	As defined in (38).	mod6	Char(2)	374	375
52	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum3	Char(2)	376	377
53	Units of services – number of days for multiple days or units of supply.	Units3	Num (4)	378	381
54	Charge – charge for the listed service	Charge3	Num (6)	382	387
55	As defined in (43).	px4	Char(5)	388	392

56	Modifier (mod7 & mod8) – 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.	mod7	Char(2)	393	394
57	As defined in (38).	mod8	Char(2)	395	396
58	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum4	Char(2)	397	398
59	Units of services – number of days for multiple days or units of supply.	Units4	Num (4)	399	402
60	Charge – charge for the listed service.	Charge4	Num (6)	403	408
61	As defined in (43).	px5	Char(5)	409	413
62	Modifier (mod9 & mod10) – 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	mod9	Char(2)	414	415
63	As defined in (38)	mod10	Char(2)	416	417
64	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum5	Char(2)	418	419
65	Units of services – number of days for multiple days or units of supply.	Units5	Num (4)	420	423
66	Charge – charge for the listed service.	Charge5	Num (6)	424	429
67	As defined in (43).	px6	Char(5)	430	434
68	Modifier (mod11 & mod12) – 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.	mod11	Char(2)	435	436
69	As defined in (38).	mod12	Char(2)	437	438
70	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum6	Char(2)	439	440
71	Units of services – number of days for multiple days or units of supply.	Units6	Num (4)	441	444
72	Charge – charge for the listed service.	Charge6	Num (6)	445	450
73	As defined in (43).	px7	Char(5)	451	455
74	Modifier (mod13 & mod14) – 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.	mod13	Char(2)	456	457
75	As defined in (38).	mod14	Char(2)	458	459
76	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum7	Char(2)	460	461

77	Units of services – number of days for multiple days or units of supply.	Units7	Num (4)	462	465
78	Charge – charge for the listed service.	Charge7	Num (6)	466	471
79	As defined in (43).	px8	Char(5)	472	476
80	Modifier (mod15 & mod16) – 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.	mod15	Char(2)	477	478
81	As defined in (38).	mod16	Char(2)	479	480
82	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum8	Char(2)	481	482
83	Units of services – number of days for multiple days or units of supply.	Units8	Num (4)	483	486
84	Charge – charge for the listed service.	Charge8	Num (6)	487	492
85	As defined in (43).	px9	Char(5)	493	497
86	Modifier (mod17 & mod18) – 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.	mod17	Char(2)	498	499
87	As defined in (38).	mod18	Char(2)	500	501
88	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum9	Char(2)	502	503
89	Units of services – number of days for multiple days or units of supply.	Units9	Num (4)	504	507
90	Charge – charge for the listed service.	Charge9	Num (6)	508	513
91	As defined in (43).	px10	Char(5)	514	518
92	Modifier (mod19 & mod20) – 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.	mod19	Char(2)	519	520
93	As defined in (38).	mod20	Char(2)	521	522
94	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum10	Char(2)	523	524
95	Units of services – number of days for multiple days or units of supply.	Units10	Num (4)	525	528
96	Charge – charge for the listed service.	Charge10	Num (6)	529	534
97	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	ppayer	Char(1)	535	535

	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				
98	As defined in (97).	spayer	Char(1)	536	536
99	As defined in (97).	tpayer	Char(1)	537	537
100	Payer Identification (payer1, payer2, payer3) – the insured's group number (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)	538	542
101	As defined in (100).	payer2	Char(5)	543	547
102	As defined in (100).	payer3	Char(5)	548	552
103	Encounter type – indicates the priority of the encounter. Emergent = 1 Urgent = 2 Elective = 3	etype	Char(1)	553	553
104	Referring Physician - State license number or NPI of the physician primarily responsible for the patient for this encounter.	rphysid	Char(10)	554	559
105	Attending Physician – State license number or NPI identifying the provider who performed the service/treatment/procedure.	pphysdocid	Char(10)	560	565
106	Operating Physician – State license number or NPI identifying the provider who performed the service/treatment/procedure.	ophysid	Char(10)	566	575
107	Charges – Sum of all charges for this encounter.	chrg_tot	Num(8)	576	583
108	Disposition – the circumstances of the patient's discharge, categories of which are defined below: Discharged to home or self care, (routine discharge) 01	pstat	Char(2)	584	585

	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				

Please provide all new categories of a data element indicate by the external code sources specified in the National Electronic Data Interchange Transaction Set Implementation Guide Section C.