Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant:	**Hartford Hospital and CTGI Glastonbury Endoscopy Center, LLC, d/b/a Glastonbury Endoscopy Center, LLC**
Docket Number:	**07-30920-CON**
Project Title:	**Establish and Operate a Freestanding Endoscopy Center in Glastonbury**
Statutory Reference:	**Section 19a-638, Connecticut General Statutes**
Filing Date:	**September 18, 2007**
Hearing Date:	**October 31, 2007**
Presiding Officer:	**Cristine A. Vogel, Commissioner**
Decision Date:	**November 21, 2007**
Default Date:	**December 17, 2007**
Staff:	**Alexis G. Fedorjaczenko** **Steven W. Lazarus**

Project Description: Hartford Hospital and CTGI Glastonbury Endoscopy Center, LLC, d/b/a Glastonbury Endoscopy Center, LLC ("Applicants") propose to establish and operate a freestanding endoscopy center to be located in a medical park on Western Boulevard in Glastonbury, Connecticut, at a total capital cost of $2,002,124.

Nature of Proceeding: On June 18, 2007, 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 in a medical park on Western Boulevard in Glastonbury, Connecticut, at a total capital cost of $2,002,124. 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* and *The Hartford Courant* on February 17, 2007. Pursuant to Section 19a-638, three individuals or an individual representing an entity with five or more people had until July 9, 2007, 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.

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on October 31, 2007. On October 2, 2007, the Applicants were notified of the date, time, and place of the hearing. On October 6, 2007 and October 13, 2007, notices to the public announcing the hearing were published in *The Hartford Courant* and *The Journal Inquirer*, respectively. Commissioner Cristine A. Vogel served as Presiding Officer. The 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-638, C.G.S.

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 Applicants' Current Utilization Statistics

1. Hartford Hospital ("Hospital") is an acute care general hospital in Hartford, Connecticut. Its main campus is located at 80 Seymour Street.

2. CTGI Glastonbury Endoscopy Center, LLC ("CTGI") is a newly formed for-profit entity created for the sole purpose of partnering with the Hospital to develop the new endoscopy center. *(October 31, 2007, Public Hearing, Testimony of Dr. Jeffrey Nestler)*

3. The Hospital and CTGI (together referred to as "Applicants") d/b/a Glastonbury Endoscopy Center, LLC ("Center") propose to establish and operate a freestanding endoscopy center to be located in a medical park on Western Boulevard in Glastonbury, Connecticut. *(June 18, 2007, Initial CON Submission, page 2)*

4. CTGI Endoscopy Center, LLC ("Bloomfield Center") is a physician owned facility providing endoscopic services in Bloomfield, Connecticut. There is some overlapping ownership with the proposed Center; however, the Bloomfield Center is a separate entity. *(October 31, 2007, Testimony of Jeffrey Nestler, M.D.)*

5. The Center's Membership Interests will be allocated as follows:

    a. The Hospital, as the Class A Member, shall hold no less than a fifty percent (50%) interest in the Company; and
    b. CTGI, as the Class B Member, shall initially hold a fifty percent (50%) membership interest, which shall be reduced on a pro rata basis in the event that the Company issues Class C Membership.

    (June 18, 2007, Initial CON Submission, pages 3-4 of Appendix 1)

6. Although the Hospital and CTGI each will have a fifty percent (50%) interest in the Center, the Hospital retains control over fundamental operational matters to ensure that the Center's activities further the Hospital's charitable purpose. *(August 1, 2007, First Completeness Response, page 6)*

7. The Center will be a freestanding endoscopy center that will diagnose and treat various diseases of the upper and lower GI tract. Emphasis at the Center will be on screening patients for colon and esophageal cancer. *(June 18, 2007, Initial CON Submission, page 2)*

8. The Center will have two procedure rooms, eight PACU recovery beds, and two step-down recovery recliners, a reception area, and support space. The Applicants state that both procedure rooms meet all the qualifications of a state licensed operating room. *(June 18, 2007, Initial CON Submission, pages 2 and 11-12 and October 26, 2007, Responses to Interrogatories, page 2)*

9. The Applicants state that there will initially be 15 physician owners of the proposed center, and that GI physicians who are not owners of the Center will also utilize the Center's facilities. *(October 31, Public Hearing Testimony)*

10. The Applicants based the need for the Center on the following factors:
    a. The large volume of procedures currently performed by GI physicians affiliated with the Hospital, and related capacity issues at existing endoscopy facilities; and
    b. Growth of endoscopy as a screening tool for evaluation of colorectal cancer as well as for upper digestive track disorders.

    (June 18, 2007, Initial CON Submission, pages 2-5 and October 31, 2007, Public Hearing Testimony)

11. The GI physicians are committed to a significant expansion of their practice into the Glastonbury area to meet increasing demand for services, and plan to establish full time office space for at least four gastroenterologists in the same medical park as the proposed center. The Applicants also plan to locate a community outreach and educational center at this site. *(June 18, 2007, Initial CON Submission, page 3 October 31, 2007, Testimony of Kevin Kinsella)*

12. The following table reports the number of endoscopic procedures by fiscal year ("FY") performed at the Bloomfield Center, along with the current capacity and utilization rate.

Table 1: Current Utilization at Bloomfield Center

	FY 2004	FY 2005	FY 2006
# of Procedures	6,556	6,632	6,735
Procedure Rooms	2	2	2
# of procedures/room	3,278	3,316	3,368
Max # of Procedures/room*	3,500	3,500	3,500
Utilization Rate	**94%**	**95%**	**96%**

*Note: * maximum number of procedures calculated by 14 cases/room x 250 days*
(August 1, 2007, First Completeness Response, page 2)

13. Dr. Jeffrey Nestler, Chief of the Division of Gastroenterology at Hartford Hospital, testified that capacity issues at the Bloomfield Center include the following factors:

- Rooms are booked daily and all blocks of time are spoken for;
- Hours have been expanded twice to accommodate volumes; and
- Average wait time to receive services is 6-8 weeks.

(October 31, 2007, Testimony of Jeffrey Nestler, M.D.)

14. Hartford Hospital reported performing 9,626 endoscopic procedures in FY 2004, 9,763 in FY 2005, and 10,531 in FY 2006. The Applicant testified that with 9 procedure rooms the Hospital is at more than 90% capacity for these procedures. *(August 1, 2007, First Completeness Response, page 2 and October 31, 2007, Testimony of Kevin Kinsella)*

15. Kevin Kinsella, Vice President of Hartford Hospital, testified that the proposed center will alleviate capacity issues at the Hospital by decreasing waiting times for patients and allowing physicians to use existing rooms at the Hospital for more ambulatory surgery. *(October 31, 2007, Testimony of Kevin Kinsella)*

16. Mr. Kinsella testified that the Hospital's new Ambulatory Surgery Center at Blueback Square will free up time in the inpatient operating rooms used by colorectal surgeons at the Hospital, but will have no impact on procedures done by GI physicians. *(October 31, 2007, Testimony of Kevin Kinsella)*

17. The Applicants stated that there will be some backfill of procedures from Hartford Hospital primary care groups at the Hospital, and also that space at the Hartford Hospital endoscopy suite will be reduced somewhat to accommodate other purposes. *(June 18, 2007, Initial CON Submission, page 7)*

18. The physicians involved in this proposal all have active privileges at Hartford Hospital. They will continue to perform procedures at Hartford Hospital for inpatients and for those outpatients who prefer to have their procedures preformed in a hospital setting and who have significant co-morbid issues that make them high risk. *(June 18, 2007, Initial CON Submission, page 3)*

19. The projected numbers of procedures to be performed in the first three years at the proposed Center are given in the following table for each member physician:

Table 2: Projected Number of Endoscopic Procedures for the Center

Physician	Year 1	Year 2	Year 3
Physician A	140	195	258
Physician C	234	327	443
Physician D	147	206	273
Physician E	153	214	284
Physician F *	238	334	449
Physician G *	204	286	229
Physician H	93	130	166
Physician I *	274	383	515
Physician J	136	190	251
Physician K *	267	375	507
Physician L	101	142	183
Physician M	140	196	260
Physician N	103	143	185
Physician O	150	211	278
Physician Q	120	168	219
Total	**2,500**	**3,500**	**4,500**

Note: For Year 1 an average estimated 5% increase from 2007 Hartford Hospital and Bloomfield GI volumes was used to develop projections for the proposed Center. Years 2 and 3 include an average estimated 40% annual increase. Projections are based on an increase in patient compliance, waiting lists, addition of new GI screening methods, and population demographics.
* indicates that these physicians are projected to take 20% of their volume to the proposed Center; all other physicians are assumed to take 10% of their volume to the proposed Center.
(September 18, 2007, Second completeness Response, page 3 and Attachment 2)

20. The Applicants indicate that while there may be some initial shifting of cases between facilities, they anticipate that volumes will eventually increase in all facilities due to increased compliance, education, and an aging population. *(June 18, 2007, Initial CON Submission, page 5)*

21. The Applicants propose to follow the Standard Practice Guidelines of the American College of Gastroenterology. Additionally, the Center's Medical Director implements all national clinical standards for Ambulatory Colonoscopy Centers.*(June 18, 2007, Initial CON Submission, page 8)*

22. The Applicants are seeking DPH licensure as a Freestanding Ambulatory Surgery Center. *(June 18, 2007, Initial CON Submission, page 9)*

23. Glastonbury Endoscopy Center, LLC will be the entity billing for the proposed service. *(June 18, 2007, Initial CON Submission, page 11)*

24. The hours of operation for the proposed Center will be Monday through Friday from 7:00 a.m. to 6:00 p.m. and eventually on Saturdays from 7:00 a.m. to 12 p.m. *(June 18, 2007, Initial CON Submission, page 6)*

25. 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 Applicants' 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

26. The total capital cost for the proposal of $2,002,124 includes the following components:

Table 3: Total Capital Cost

Medical Equipment (purchase)	$330,960
Non-Medical Equipment (purchase)	$100,040
Construction/Renovation	$618,550
Other	$687,574
Total Capital Expenditure	**$1,737,124**
Medical Equipment (Capital Lease)	$265,000
Total Capital Cost	**$2,002,124**

(June 18, 2007, Initial CON Submission, page 11)

27. The construction costs consist of the following:

Table 4: Construction Cost Breakdown

Building Work	$816,200
Architectural and Engineering	$48,000
Contingency	$75,000
Other	$55,325
Subtotal	**$994,525**
Tenant Improvements Allowance	320,650
Total	**$673,875**

(June 18, 2007, Initial CON Submission, page 12)

28. Construction of the Center includes approximately 5,830 square feet of tenant improvements inside a newly constructed "shell" facility. Construction is scheduled to begin in 2007, with licensure by the State of Connecticut Department of Public Health to occur in October 2008 and commencement of operations in November 2008. *(June 18, 2007, Initial CON Submission, pages 11-12)*

29. The funding sources for the proposal are the Applicant's equity, a 7-year conventional loan, and 3-year lease financing. *(June 18, 2007, Initial CON Submission, pages 12)*

30. Profits and losses will be divided 50/50 among the two applicants. *(June 18, 2007, Initial CON Submission, page 11)*

31. The Applicant is projecting the following incremental revenues and expenses for Glastonbury Endoscopy Center for the first three years of the project:

Table 5: Incremental Financial Projections for Glastonbury Endoscopy Center

Description	FY 2009	FY 2010	FY 2011
Incremental Revenue from Operations	$1,362,500	$1,963,500	$2,601,000
Incremental Total Operating Expense	$1,153,401	$1,467,072	$1,799,457
Incremental Gain from Operations	**$209,099**	**$496,428**	**$801,543**

(September 18, 2007, Second completeness Response, Attachment 9)

32. The Hospital projects that the shift of hospital volume to the Center will result in incremental losses of $137,116, $179,551, and $12,302 for FYs 2009, 2010, and 2011, respectively. The Hospital's financial analysis does not include any replacement volume. *(September 18, 2007, Second completeness Response, Attachment 9 and June 18, 2007, Initial CON Submission, page 7)*

33. The Hospital projects that its return on investment will offset the loss of annual revenue from the migrated volume beginning in FY 2012, with the cumulative deficit being offset in FY 2013. *(October 26, 2007, Responses to Interrogatories, page 4)*

34. The projected payer mix for the Center, calculated using Gross Patient Revenue, is as follows:

Table 6: Three-Year Projected Payer Mix for the Glastonbury Center

Payer Mix	Year 1	Year 2	Year 3
Medicare	44%	44%	44%
Medicaid	10%	10%	10%
Champus and TriCare	1%	1%	1%
Total Government	**55%**	**55%**	**55%**
Commercial Insurers	39%	39%	39%
Uninsured	6%	6%	6%
Total Non-Government	**45%**	**45%**	**45%**
Total Payer Mix	**100%**	**100%**	**100%**

(August 1, 2007, First Completeness Response, Attachment 2)

35. The Applicant indicated that the payer mix at both the Hospital and the Bloomfield Center will not change upon implementation of the Center. *(September 18, 2007, Second completeness Response, page 5)*

36. There is no State Health Plan in existence at this time. *(June 18, 2007, Initial CON Submission, page 2)*

37. The Applicants have adduced evidence that this proposal is consistent with their long-range plans. *(June 18, 2007, Initial CON Submission, page 2)*

38. The Applicants have improved productivity and contained costs through energy conservation, reengineering, and other activities. *(October 31, 2007, Public Hearing Testimony)*

39. The proposal will not result in any change to the Applicants' teaching or research responsibilities. *(June 18, 2007, Initial CON Submission, page 9)*

40. There are no distinguishing characteristics of the Applicants' patient/physician mix. *(June 18, 2007, Initial CON Submission, page 9)*

41. The Applicants have sufficient technical, financial and managerial competence and expertise to provide efficient and adequate service to the public.*(June 18, 2007, Initial CON Submission, Attachment V and November 5, 2007, Late file 1)*

42. The Applicants' rates are sufficient to cover the proposed capital and operating costs associated with the proposal. *(September 18, 2007, Second completeness Response, Attachment 9)*

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.

Hartford Hospital ("Hospital") and CTGI Glastonbury Endoscopy Center, LLC ("CTGI") (together referred to as "Applicants") d/b/a Glastonbury Endoscopy Center, LLC ("Center") propose to establish and operate a freestanding endoscopy center to be located in a medical park on Western Boulevard in Glastonbury, Connecticut. The Hospital and CTGI will each hold 50% membership interest in the Center, yet the Hospital will retain control over fundamental operational matters to ensure that the Center's activities further the Hospital's charitable purpose. Profits and losses will be divided 50/50 between the two applicants.

The Center will be a freestanding endoscopy center that will diagnose and treat various diseases of the upper and lower GI tract, with an emphasis on screening patients for colon and esophageal cancer. The Center will have two procedure rooms, which will both meet all the qualifications of a state licensed operating room. The Applicants based the need for the Center on the large volume of procedures currently performed by GI physicians affiliated with the Hospital and related capacity issues at their existing facilities, as well as on the growth of endoscopy services, particularly routine cancer screening procedures.

The existing facilities at which the Applicants practice are at or near capacity. The total number of outpatient endoscopy procedures performed at CTGI Endoscopy Center, LLC in Bloomfield were 6,556 in FY 2004, 6,632 in FY 2005, and 6,735 in FY 2006, with a utilization rate of more than 94%. For the same time period, the Hospital states that they were at more than 90% capacity with 9,626 endoscopy procedures in 2004, 9,763 in FY 2005, and 10,531 in FY 2006. OHCA recognizes that the Applicants have an established referral patient base. Based on the evidence, the Applicants have demonstrated that the proposal will improve both the accessibility and quality of endoscopy services in the region.

The proposal's capital cost of $2,002,124 will be financed through equity contributions, a conventional loan, and a capital lease. This CON proposal projects that the Center will realize an incremental gain from operations in each of first three fiscal years of operations, FY 2009 through FY 2011. The CON proposal also projects that the Hospital will experience an incremental loss in each of the first three years of operation, due to the shift of Hospital volume to the Center. Future volume is anticipated to increase for all facilities due to increased compliance, education and an aging population; the Hospital projects that its return on investment will offset the loss of annual revenue beginning in FY 2012, with the cumulative deficit being offset in FY 2013. Although OHCA can not draw any conclusions, the Applicants' financial projections appear to be reasonable. Therefore, OHCA finds that the CON proposal financially feasible and cost effective. Further, the proposal will not adversely impact consumers of health care services or payers for such services.

Order

Based upon the foregoing Findings of Fact and Rationale, the Certificate of Need request of Hartford Hospital and CTGI Glastonbury Endoscopy Center, LLC ("Applicants") d/b/a Glastonbury Endoscopy Center, LLC to establish and operate a freestanding endoscopy center to be located in a medical park on Western Boulevard in Glastonbury, Connecticut, at a total capital cost of $2,002,124 is hereby GRANTED, subject to conditions.

1. This authorization expires on November 21, 2007. Should the Applicants' project not be completed by that date, the Applicants must seek further approval from OHCA to complete the project beyond that date.

2. The Applicants shall report to OHCA, in writing, the date of the commencement of operations at Glastonbury Endoscopy Center, LLC to OHCA within 30 days of the commencement date.

3. The Applicants shall not exceed the approved capital cost of $2,002,124. In the event that the Applicants learn of potential cost increases or expects that the final project costs will exceed those approved, the Hospital shall notify OHCA immediately.

4. Should the Applicants intend or plan any change in the scope of services provided, expand the existing services beyond the two (2) operating rooms or location of the outpatient endoscopy center in Glastonbury, 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. The ownership interest of Hartford Hospital shall not fall below 50%. If Glastonbury Endoscopy Center, LLC proposes in the future to change the ownership interests of Hartford Hospital, prior OHCA approval will be required.

6. Glastonbury 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 Glastonbury 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

Signed by Commissioner Vogel on November 21, 2007

_____ _____

Date Cristine A. Vogel
Commissioner

CAV:agf

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 Worker's Compensation = B	ppayer	Char(1)	535	535

	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.