ABSTRACT

This material provides documentation for users of the 2016 National Ambulatory Medical Care Survey (NAMCS) micro-data file. NAMCS is a national probability sample survey of visits to office-based physicians and community health centers (CHCs) conducted by the National Center for Health Statistics (NCHS). It is part of the National Health Care Surveys, which measure health care utilization across a variety of health care providers. This public use file and documentation is for the “traditional” or office-based component of NAMCS. Data on CHCs are being released separately. A summary of changes for 2016 is presented first which highlights all of the most important information for data users. Section I, "Description of the National Ambulatory Medical Care Survey," includes information on the scope of the survey, the sample, field activities, data collection procedures, medical coding procedures, population estimates, and sampling errors. Section II provides technical information about variables on the file, as well as a list of all physician specialties eligible for sampling. Section III contains marginal data and estimates for selected items on the data record. The appendixes contain sampling errors, instructions and definitions for completing the Patient Record form, and lists of codes used in the survey.

SUMMARY OF CHANGES FOR 2016

The 2016 NAMCS micro-data file is similar to the 2015 file, but there are some important changes. These are described in more detail below and primarily reflect changes in sampling design, data collection, data processing, and survey instruments -- the automated Patient Record form and Physician Induction Interview form.

A. No More State-Based Estimation

The sampling design changed for 2016. From 2012-2015, the design targeted varying numbers of states, but no states were targeted in 2016. The 2016 NAMCS sampling design utilized a stratified two-stage sample, with physicians selected in the first stage and visits in the second stage. A stratified list sample of physicians was selected from the master files maintained by the American Medical Association (AMA) and American Osteopathic Association (AOA). See page 15 for more information.

As in years prior to 2012, there are two weighting variables on the file, one to make visit estimates (PATWT) and one to make physician estimates (PHYSWT). PATWT can be used to make national, regional, and metropolitan statistical area (MSA)/non-MSA estimates. PHYSWT is used to make estimates of office-based physicians who are in-scope for NAMCS, but this weight is only based on physicians who saw patients during their reporting period. Physicians who participated in the survey but did not see any patients during their reporting period are not included, and those who refused to participate are not included. Because of these limitations, physician-level estimates derived from NAMCS visit data are not necessarily generalizable to all office-based physicians. In order to include these other groups (for example, those who did not provide any sampled visit data but did respond to the induction interview), provider-level files, based on the physician induction interview only, are available in the NCHS Research Data Center.

B. Data Collection and Comparability of 2016 NAMCS Estimates with Previous Years of Data

For 2016, the main mode of data collection continued to be the automated laptop-assisted instrument used since 2012. But a second mode of data collection was used for the first time in 2016 involving direct submission of electronic health records (EHR). This mode was available to 585 physicians already selected in the 2016 sample who had also registered their intent to participate in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Programs: Promoting Interoperability (PI) (formerly known as Meaningful Use), and the Merit-based Incentive Payment System (MIPS), by submitting EHR data directly to NCHS. The data collected through direct EHR submission have presented many processing challenges and are not included in the 2016 NAMCS Public Use File; they are expected to be available in the NCHS Research Data Center at some future date. This public use file only includes data abstracted by U.S. Census Bureau field representatives.

Research was conducted to assess any data anomalies between 2015 and 2016 data. To accomplish this, more than 30 tables of 2016 estimates were compared with the same tables of 2015 estimates. The variables that were compared included most of those published in the annual survey web tables. Significant changes between the two years were noted and investigated. While many estimates were not statistically different in each year, some unexpected results were found. These may reflect actual differences, or they may be related to changes in item format, the automated data collection system or the increase in Census abstraction to collect visit information. Data users are advised to take these factors into account when using these items or comparing them with previous years. Specific findings include the following, with results being weighted to national estimates:

---The percentage of office visits increased for physicians in the following specialties: pediatrics (from 9.6% in 2015 to 15.4% in 2016) and dermatology (from 3.7% in 2015 to 5.7% in 2016); and decreased for orthopedic surgery (from 5.7% to 3.4%).

---Visits made to freestanding clinics or urgicenters increased from 2.5% in 2015 to 6.1% in 2016.
---Visits in which medication was the reason for visit decreased from 3.6% in 2015 to 2.0% in 2016; and visits in which counseling was the reason for visit decreased from 2.7% in 2015 to 1.5% in 2016.

---The percentage of visits that included the following chronic conditions decreased from 2015 to 2016: arthritis (from 16.0% to 10.9%); and diabetes (from 15.2% to 11.5%).

---The percentage of visits that included the following services decreased from 2015 to 2016: Upper gastrointestinal endoscopy/EGD (from 0.7% to 0.1%), home health care (from 1.1% to 0.3%), and MRI (from 2.2% to 1.5%). The percentage of visits that included cryosurgery increased from 0.8% to 1.3%.

NCHS staff will continue to monitor these and other changes in an effort to better assess how much may be attributed to data collection and processing vs. real-world treatment patterns.

C. Nonresponse Bias

Physician-level response (successful collection of data in the Physician Induction Interview) for the core (non-Community Health Center [CHC]) NAMCS sample was 46.0% (weighted) in 2016, but only 39.3% (weighted) of physicians (677 physicians, unweighted) provided data for at least one sampled visit and, thus, are the only ones to have data in the public use file. However, this rate was higher than the 29.5% (weighted) participation rate noted for 2015.

Because of staff resource limitations, a detailed analysis of nonresponse bias at both levels of physician response was last conducted by NCHS using 2012 data (1). Nonresponse bias should be taken into consideration when analyzing and interpreting 2016 data. In addition to survey nonresponse, rates of missingness may be high for some survey items. Item nonresponse is discussed in more detail in Section I.

D. Diagnosis, Cause of Injury, and Procedure Coding

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) (2) was used to code 2016 NAMCS data on physician diagnosis and cause of injury. It replaced the International Classification of Diseases, Ninth Revision (ICD-9-CM) (3), which had been used to code NAMCS data since 1979. Procedures ordered or provided at the sampled visit were coded using the ICD-10-CM/PCS (Procedure Classification System) (4), which replaced the ICD-9-CM, Volume 3, Procedure Classification (3). A recent report analyzed comparability between the two classifications for NAMCS data (5).

As noted on the NCHS ICD-10-CM website, ICD-10-CM codes have a completely different structure from ICD-9-CM codes. ICD-10-CM diagnosis codes contain letters and numbers and have 3 to 7 characters. ICD-10-CM cause of injury codes are within the main diagnosis classification and follow the same structure as diagnoses. ICD-10-CM/PCS codes are maintained by the Centers for Medicare and Medicaid Services and include up to 7 alphanumeric digits which reflect the broad procedure type (e.g., medical and surgical), the larger body system (e.g., lymphatic and hemic systems), root operation (e.g., drainage), body part (e.g., spleen), approach (e.g., open), device (e.g., drainage device) and a qualifier (e.g., diagnostic). There are nearly 5 times as many diagnosis codes in ICD-10-CM than in ICD-9-CM, and nearly 19 times as many procedure codes in ICD-10-CM/PCS than in ICD-9-CM, Volume 3.

The added detail required to correctly code diagnosis, cause of injury, and procedure, is not always present in NAMCS verbatim text reporting fields for these items. Especially with the procedure data, many of the resulting codes do not include all dimensions. This is explained more fully in the Medical Coding Section on page 29. NAMCS is using ICD-10-CM/PCS for 2016 only and plans are in place to switch to CPT (Current Procedural Terminology) codes for 2017 data.

Data users should be aware that ICD-10-CM codes for diagnosis and cause of injury have been truncated to 4 digits on the public use data file. This decision was made to preserve as much detail as possible while still allowing us to process the data efficiently and present it safely. More information is provided in the Medical Coding section on page 28.

E. Race and Ethnicity

Item nonresponse rates for race and ethnicity were similar to those in 2015 and remained high. In 2016, the missing rate for race was 27.7 percent (unweighted) and 29.2 percent (weighted). For ethnicity, it was 25.6 percent (unweighted) and 24.5 percent (weighted).

Starting with 2009 data, NAMCS adopted the technique of model-based single imputation for missing race and ethnicity data, as described in more detail in Section I. This model was used to impute 2016 data, with modifications which reflect the current sampling design.

Users should be aware that high percentages of item nonresponse may lead to biased estimates, particularly if the imputation algorithm omitted a variable of importance, and that the single imputation algorithm may underestimate some standard errors. We anticipate this underestimate to be fairly small for most estimates, particularly those with design effects of 5 or greater. However, standard errors may be underestimated more substantially for those domains with design effects under 5. For more information about the decision to adopt a model-based single imputation methodology, see the 2009 NAMCS Public Use Data File Documentation: (ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/doc09.pdf).

F. Laboratory Results

For 2016, the decision was made to include laboratory test results (cholesterol, high density lipoprotein, low density lipoprotein, triglycerides, HbA1c, blood glucose, and serum creatinine) on the public use file. Response rates for these items were better than in 2015. However, except for some extreme outliers, the lab data have not been edited and are included for data users who wish to explore them further.

G. Regional Estimates

Data users should be aware that the 2016 NAMCS Public Use Data File only includes 677 physicians. This is a much smaller number of respondents than in previous years and resulted mainly from the splitting off of 585 physicians from the original sample of 3,699 physicians. This group of 585 physicians was able to use direct transmission of EHR data to fulfill their requirements to participate in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Programs: Promoting Interoperability (PI) (formerly known as Meaningful Use), and the Merit-based Incentive Payment System (MIPS). However, direct EHR data had to be processed separately and could not be included in this release of the public use data file.

As a result of the reduced sample size, certain limitations become evident. When the data are analyzed by region, there are extremely low numbers of certain specialties reporting in each region. For example, in the Midwest (REGIONOFF=2), none of the specialty groups has more than 26 physicians, and some have fewer than 10 physicians reporting. We therefore recommend using the SPECCAT variable (primary care, surgical care, or medical care) rather than SPECR (specialty group) when conducting regional analyses by specialty group.

H. Survey Items

The 2016 instrument was similar in many respects to that used for 2015, but there were a number of changes. Below is a description of all new, modified, and deleted items pertaining to the 2016 NAMCS public use file.

1. New or Modified Items

NOTE: The headings and corresponding section locations reflected in the 2016 NAMCS Patient Record Sample Card may not be identical to those in the automated electronic Patient Record Form. The Sample Card (available at the Ambulatory Health Care Data website) is a general representation of the automated instrument, using a more easily read format that is similar to the original paper forms used in earlier years.

Injury

- For the question, "Did the injury/trauma, overdose/poisoning or adverse effect occur within 72 hours prior to the date and time of this visit?", the response category "Not applicable" from 2015 was removed in 2016.

- Recoded item: This item, INJURY_ENC (type of encounter for injury visits) was added to provide data users with additional data on injury visits. Because NCHS is truncating the last 3 digits of the ICD-10-CM code on the public use file, the 7th digit for injury codes is not available. This digit provides information on whether the injury visit was an initial encounter, subsequent encounter, or sequela. We have created a variable with these categories that can be used to regain some of this lost information. Because records can have multiple injury codes and some might have different 7th digits, we are not able to provide this information for each injury code on the record. We include only one variable which contains each category (initial, subsequent, sequela) along with additional categories indicating multiple types, but these are not linked to individual injury codes on the record.

Provider's diagnosis for this visit

- In the chronic conditions checklist, three new checkboxes were added: Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity Disorder (ADHD), Hepatitis B and Hepatitis C.

- Collection of the diagnosis item changed; in 2015 there was a diagnosis look up list in the instrument which accompanied the diagnosis text fields. For 2016, diagnoses were entered in one text field for each diagnosis, with no look up list.

Services

- Under Laboratory tests, "Hepatitis testing/Hepatitis panel" was changed to "Hepatitis testing/panel"; "Lipid profile" was changed to "Lipid profile/panel"; and "Urinalysis" was changed to "Urinalysis (UA) or urine dipstick"

- Under Health education/Counseling, "Asthma" was changed to "Asthma education".

Providers and Disposition

- Under Visit Disposition, "Return to referring physician" was changed to "Return to referring physician/provider" and "Refer to other physician" was changed to "Refer to other physician/provider".

Tests

- In 2016, indication for either mg/dL or µmol/L as the unit for the most recent serum creatinine test result was added. All responses were converted to mg/dL for the public use file.

- For 2015, the low response rate among physicians who would have been given the lab questions (only primary care specialties and cardiovascular disease specialties were asked these questions) and possible instrument and data processing problems meant that we did not have sufficient data on lab tests to include them on the file for 2015. For 2016, our response rates for the lab questions improved so that we were able to include these variables on the public use file again.

From the Automated Physician Induction Interview Form

- In the section "Does the reporting location have any of the following computerized capabilities?", three new questions were added:

  Do you prescribe controlled substances?

  If yes, are prescriptions for controlled substances sent electronically to the pharmacy?

  Does the reporting location have the computerized capability for providing data to create reports on clinical care measures for patients with specific chronic conditions (e.g., HbA1C for diabetics)?

- Modified item (replaces older item, see under Deleted Items):

  How do you send patient health information to providers outside of your office or group? Responses can include any of these: Electronically (EHR, web portal, or online registries); Via paper-based methods (Fax, eFax, or mail); We do not send any patient health information to providers outside of our office or group; Unknown; Refused

- Modified item (replaces older item, see under Deleted Items):

  How do you receive patient health information from providers outside of your office or group? Responses can include any of these: Electronically (EHR, web portal, or online registries), Via paper-based methods (Fax, eFax, or mail), We do not receive any patient health information from providers outside of our office or group, Unknown, Refused

- Modified item (replaces older item, see under Deleted Items):

  Do you electronically send patient health information to another provider whose EHR system is different from your own? (Yes, No, Unknown, Refused to Answer)

- Modified item (replaces older item, see under Deleted Items):

  Do you electronically receive patient health information from another provider whose EHR system is different from your own? (Yes, No, Unknown, Refused to Answer)

- New item: Do you electronically send or receive hospital discharge summaries to or from providers outside of your medical organization/the CHC? –Responses can include: Send electronically, Receive electronically, Do not send or receive, Unknown, Refused

- New item: Do you electronically send or receive Emergency Department notifications to or from providers outside of your medical organization/the CHC? -- Responses can include: Send electronically, Receive electronically, Do not send or receive, Unknown, Refused

- New item: Do you electronically send or receive summary of care records for transitions of care or referrals to or from providers outside of your medical organization/the CHC? – Responses can include: Send electronically, Receive electronically, Do not send or receive, Unknown, Refused

- New item: Can patients seen at the reporting location/CHC do the following online activities? – Responses can include: View their medical record online, Download and transmit health information in the electronic medical record to their personal files, Request corrections to their electronic medical record, Enter their health information online (e.g. weight, symptoms), Upload their data from self-monitoring devices(e.g. blood glucose readings), None of the above, Unknown, Refused

Modified items: Response categories were changed from these used in 2015:

1) Yes, used routinely
2) Yes, but not used routinely
3) Yes, but turned off or not used
4) No
5) Unknown

to a shorter list for 2016:
1) Yes
2) No
3) Unknown

for the following EHR/EMR items:

- Does the reporting location have the computerized capability for recording patient history and demographic information?
- If 'yes' to recording patient history and demographic information, does this include a patient problem list?
- Does the reporting location have the computerized capability for recording clinical notes?
- Does the reporting location have the computerized capability for recording patient's medications and allergies?
- Does the reporting location have the computerized capability for reconciling lists of patients' medications to identify the most accurate list?
- Does the reporting location have the computerized capability for providing reminders for guideline-based interventions or screening tests?
- Does the reporting location have the computerized capability for ordering prescriptions?
- If 'yes' to computerized capability for ordering prescriptions, are prescriptions sent electronically to the pharmacy?
- If 'yes' to computerized capability for ordering prescriptions, are warnings of drug interactions or contraindications provided?
- Does the reporting location have the computerized capability for ordering lab tests?
- Does the reporting location have the computerized capability for viewing lab results?
- Does the reporting location have the computerized capability for ordering radiology tests?
- Does the reporting location have the computerized capability for viewing imaging results?
- Does the reporting location have the computerized capability for identifying patients due for preventive or follow-up care in order to send patients reminders?

- Does the reporting location have the computerized capability for providing data to generate lists of patients with particular health conditions?
- Does the reporting location have the computerized capability for providing patients with clinical summaries for each visit?
- Does the reporting location have the computerized capability for exchanging secure messages with patients?

2. Deleted items

The following items were removed from the 2016 Public Use FIle:

- The geographic variable FIPSSTOFF (state where majority of physician's sampled visits occurred) was removed from the public use file for 2016. We are no longer sampling at the state-level. Likewise, there is no need for a state weighting variable so PATWTST was removed.

- Injury variables: INJR1, INJR2, INJPOISADR1, INJPOISADR2, INJDET_TRD, INJDETR1_TRD, and INJDETR2_TRD are no longer included on the public use file. These variables were all based on and edited using data collected on patient's reason for visit, cause of injury, and diagnosis, in conjunction with the usual Patient Record Form (PRF) injury items. They were developed to provide additional definitions of injury-related visits which conformed as closely as possible to NHCS's Office of Analysis and Epidemiology definitions of injury, and also to provide variables which could be used for trending with previous formats for NAMCS injury variables. With the adoption of ICD-10-CM, the final definition for injury categories is still being developed by OAE. Therefore, we have only included variables based on our own current definition as described in the Public Use File Documentation.

- All numeric recodes for ICD-10-CM diagnosis, cause of injury and procedure codes were removed from the public use file. It is no longer possible for us to create the numeric recodes because of the structure of ICD-10-CM.

From the Physician Induction Interview, the following EMR/EHR items were deleted:

- Are there plans to apply for stage 1 Meaningful Use of Health IT incentive payments?

- Are there plans to apply for Stage 2 incentive payments?

- Has your practice made an assessment of the potential risks and vulnerabilities of your electronic health information within the last 12 months?

- Does your EHR have the capability to electronically send health information to another provider whose EHR system is different from your system? (Note: This item was replaced with a new question and format (see under New or Modified Items.)

- Does the reporting location have the computerized capability for recording and charting vital signs?

- Does the reporting location have the computerized capability for recording patient smoking status?

- If yes to computerized capability for ordering prescriptions, are drug formulary checks performed?

- If yes to computerized capability for ordering lab tests, are orders sent electronically to the lab?
- Can the EHR/EMR automatically graph a specific patient's lab results over time?
- Does the reporting location have the computerized capability for identifying educational resources for patients' specific conditions?
- Does the reporting location have the computerized capability for reporting clinical quality measures to federal or state agencies (such as CMS or Medicaid)?
- Does the reporting location have the computerized capability for electronic reporting to immunization registries?
- Does the reporting location have the computerized capability for providing patients the ability to view online, download or transmit information from their medical record?
- How do you electronically share patient health information? (EHR/EMR, Web portal, Other electronic methods, Unknown, refused) (Note: This item was replaced with a new question and format (see under New/Modified Items.)
- Is the patient health information that you share electronically sent directly from your EHR system to another EHR system?
- With what types of providers do you electronically share patient health information? (Ambulatory providers inside your office/group, ambulatory providers outside your office/group, hospitals with which you are affiliated, hospitals with which you are not affiliated, behavioral health providers, long-term care providers, home health providers, unknown, refused)
- Are you able to electronically find health information (e.g., medications, outside encounters) from sources outside of the office for your patients?
- How do you look up patient health information from sources outside of the office? (Through your EHR/EMR, Web portal separate from EHR/EMR, View only or restricted access to other provider's EHR system, other electronic method, unknown, refused)
- What types of information do you routinely look up? (Lab results, imaging reports, patient problem lists, medication lists, other)
- Do you routinely incorporate the information you look up into your EHR?
- Do you take care of patients after they are discharged from an inpatient setting?

CONTACT INFORMATION:
For questions, comments, or suggestions, please contact the Ambulatory and Hospital Care Statistics Branch at 301-458-4600, or send email to ambcare@cdc.gov.

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I. DESCRIPTION OF THE NATIONAL AMBULATORY MEDICAL CARE SURVEY

A. INTRODUCTION

This micro-data file contains data collected in the 2016 National Ambulatory Medical Care Survey (NAMCS). NAMCS is a national probability sample survey conducted by the Division of Health Care Statistics, National Center for Health Statistics (NCHS). For 2016, the sampling design allowed for the estimation of ambulatory medical care visits to office-based physicians and community health centers (CHCs) nationally and within the four U.S.Census Bureau regions (Northeast, Midwest, South, and West). Only visits to office-based physicians are included in this data file. Visits to CHCs are not included. A separate file containing CHC visits to both physicians and non-physician practitioners (physician assistants, nurse practitioners, and nurse midwives) is planned for a future release.

The main mode of data collection for the 2016 NAMCS was a computer-assisted automated tool. U.S. Census Bureau Field Representatives abstracted data from medical charts using a laptop computer and an automated survey instrument. Data were obtained for a total of 13,165 sampled visits.

The second mode of data collection was the first attempt by NCHS to collect data directly from electronic health records. A total of 585 physicians who had used NCHS's National Health Care Surveys Registry (https://www.cdc.gov/nchs/dhcs/nhcs_registry_landing.htm) to register their intent to participate in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Programs: Promoting Interoperability (PI) (formerly known as Meaningful Use), and the Merit-based Incentive Payment System (MIPS) were included in this mode. These 585 physicians were also in the NAMCS sample frame. The Registry allows physicians to participate in specialized or public health reporting through electronic data submission in order to comply with CMS program goals. In order to participate, they agreed to submit EHR data directly to NCHS. These EHR data are not included in the 2016 NAMCS Public Use File but are expected to be available in the NCHS Research Data Center at a future date. For more on sampling and data collection see below.

Please note the following important points concerning analysis of NAMCS data on this micro-data file:

PATIENT VISIT WEIGHT

Micro-data file users should be fully aware of the importance and proper use of "patient visit weight" used to produce national and regional estimates. Information about the patient visit weight is presented on pages 2 and 34. If more information is needed, the staff of the Ambulatory and Hospital Care Statistics Branch can be consulted by calling (301) 458-4600 during regular working hours or by sending an email inquiry to ambcare@cdc.gov.

RELIABILITY OF ESTIMATES

Researchers should also be aware of the reliability or unreliability of survey estimates. The National Center for Health Statistics considers an estimated number of visits or a visit rate to be reliable if it has a relative standard error of 30 percent or less (i.e., the standard error is no more than 30 percent of the estimate) and it is based on at least 30 sample records. NCHS recently released new guidelines for determining the reliability of proportions (6). These standards are based on a minimum denominator sample size and on the absolute and relative widths of a confidence interval calculated using the Clopper-Pearson method. Additional information about relative standard errors is presented in Appendix I. If you have questions, do not hesitate to consult the staff of the Ambulatory and Hospital Care Statistics Branch.

B. SCOPE OF THE SURVEY

The basic sampling unit for NAMCS is the physician-patient encounter or visit. Traditionally, only visits to the offices of nonfederally employed physicians classified by the American Medical Association (AMA) or the American Osteopathic Association (AOA) as "office-based, patient care" were included in NAMCS. Physicians in the specialties of anesthesiology, pathology, and radiology are excluded from the physician universe. However, starting in 2006, in addition to the traditional sample, NAMCS included a sample of community health centers, using information from the Health Resources and Services Administration and the Indian Health Service to construct a sampling frame. From each sampled community health center, an additional sample of health care providers was selected, which could include physicians as well as non-physician practitioners -- physician assistants, nurse practitioners, and nurse midwives.

From 2006, when NAMCS added the CHC stratum, through 2011, visits to CHC-sampled physicians were included with visits to traditionally sampled office-based physicians on the data files. Starting with 2012, however, only visits to office-based physicians are included on the NAMCS public data products and the information provided in this documentation pertains only to the traditional (core) office-based component of NAMCS. CHC visits to physicians as well as non-physician practitioners sampled as part of the CHC panel were released as separate public use files for 2012 and 2013, and future years are forthcoming.

Types of contacts not included in the 2016 NAMCS were those made by telephone, those made outside the physician's office (for example, house calls), visits made in hospital settings (unless the physician has a private office in a hospital and that office meets the NAMCS definition of “office”), visits made in institutional settings by patients for whom the institution has primary responsibility over time (for example, nursing homes), and visits to doctors’ offices that are made for administrative purposes only (for example, to leave a specimen, pay a bill, or pick up insurance forms).

C. SAMPLING FRAME AND SIZE OF SAMPLE

The sampling frame for the 2016 NAMCS (core sample, not including CHC delivery sites) was composed of all physicians listed in the master files maintained by the AMA and AOA, at a point roughly 6 months prior to the start of the survey year, who met the following criteria:

-- Office-based or hospital-employed, as defined by the AMA and AOA;

-- Principally engaged in patient care activities;

-- Nonfederally employed;

-- Not in specialties of anesthesiology, pathology, or radiology

-- Younger than 85 years of age at the time of the survey.

Physicians whom the AMA classifies as “hospital-employed” were added to the sampling frame starting with the 2014 NAMCS. This expansion of the NAMCS physician sampling frame is due to concerns that NAMCS was not covering visits made to office-based practices which are owned by hospitals, and to increases in reported hospital purchases of physician practices in recent years.

The 2016 NAMCS traditional or core sample included 3,699 physicians: 3,474 Medical Doctors and 225 Doctors of Osteopathy. Sample physicians were screened at the time of the survey to assure that they met the above-mentioned criteria. A total of 1,377 physicians did not meet all of the criteria and were ruled out of scope (ineligible) for the study. The most frequent reasons for being out of scope were that the physician did not see ambulatory patients, was retired, or was not office-based. Eligibility for another 242 sample physicians was unknown.

Of the 2,080 in-scope (eligible) physicians, 677 submitted data for sample patient visits in the study. Data were collected for 13,165 visits by U.S. Census Bureau Field Representatives.

A total of 185 physicians saw no patients during their assigned reporting period because of vacations, illness, or other reasons for being temporarily not in practice and hence did not provide any PRFs. Of the 677 physicians for whom PRFs were abstracted, 536 participated fully or adequately (i.e. at least half of the PRFs expected, based on the total number of visits during the reporting week, were submitted), and 141 participated minimally (i.e. fewer than half of the expected number of PRFs were submitted). The unweighted response rate for visit data was 32.4 percent (32.7 percent weighted), based on the number of full responders and those who saw no patients during their sample week. The weighted participation rate was 39.3 percent based on the total of full and minimal responders including those who saw no patients during their reporting week (Table 1). Response and participation rates by Census region are shown in Table 2.

D. SAMPLING DESIGN

The sampling design changed for 2016. From 2012-2015, the design targeted varying numbers of states, but no states were targeted in 2016. The 2016 NAMCS sampling design utilized a stratified two-stage sample, with physicians selected in the first stage and visits in the second stage. A stratified list sample of physicians was selected from the master files maintained by the American Medical Association (AMA) and American Osteopathic Association (AOA).

The sampling (hard) strata were defined by Census region and 15 broad physician specialty groups (General and Family Practice, Osteopathy, Internal Medicine, Pediatrics, Obstetrics and Gynecology, General Surgery, Orthopedic Surgery, Cardiovascular Diseases, Dermatology, Urology, Psychiatry, Neurology, Ophthalmology, Otolaryngology, and a residual category for All Other Specialties). Physicians were given a random number and assigned to their respective sampling stratum. Within each sampling stratum, they were sorted first by Census division.

Within Census division, physicians were next sorted by MSA status (location in a metropolitan statistical area or not), based on Office of Management and Budget designations from Census 2010 data. Within MSA status, physicians were then sorted by their practice type (primary care, surgical, medical specialty). Within each of the implicit strata defined by Census division, MSA status, and practice type, physicians were ordered by the previously assigned random number. Within each of the 60 hard strata, a systematic random sample was selected from the list of sorted physicians. On average, about 62 physicians were selected from within hard strata, with actual numbers ranging from 50 to 129.

The final stage was the selection of patient visits within the annual practices of sample physicians. This involved two steps. First, the total physician sample was divided into 52 subsamples using systematic sampling from a list in which the physicians were sorted in the order of their selection to the total sample and those subsamples were then randomly assigned to the 52 weeks in the survey year. Second, a systematic random sample was selected from a chronologic list of visits seen during the assigned week. Visit sampling was mainly conducted by Census Field Representatives. The sampling rate varied for this final step from a 100-percent sample for very small practices to a 10-percent sample for very large practices as determined in the physician interview. The method by which the sampling rate was determined is available from the Ambulatory and Hospital Care Statistics Branch (AHCSB).

Table 1. Number of physicians in the universe, sample, and response categories plus rates for response and participation by sampled specialty group: National Ambulatory Medical Care Survey, 2016

Physician specialty group at sampling	Universe (1)	Total	Out of Scope and non-locatable	Out of Scope and locatable	In Scope	Eligibility Status Unknown	Respon-dents	Estimated Proportion for Unknown eligibility	Estimate of in Scope Physicians	Respon-dents	Response rates: unweighted (weighted) (2)	Parti ci-pants (3)	Partici pation rate: weighted (3)
Total	621,257	3,699	49	1,328	2,080	242	721	0.61	2,228	721	32.37(32.69)	862	39.32
General and family practice	100,511	490	10	191	269	20	83	0.58	281	83	29.57(29.95)	109	39.09
Internal medicine	94,848	247	6	121	104	16	35	0.46	111	35	31.42(29.42)	43	36.53
Pediatrics	69,772	234	2	97	120	15	53	0.55	128	53	41.31(43.12)	60	47.77
General surgery	20,998	229	3	95	111	20	44	0.54	122	44	36.13(36.17)	46	37.98
Obstetrics and gynecology	38,256	235	6	76	139	14	45	0.65	148	45	30.39(31.24)	55	38.18
Orthopedic surgery	22,644	235	1	69	141	24	37	0.67	157	37	23.55(24.32)	48	31.32
Cardiovascular diseases	19,560	229	2	59	154	14	47	0.72	164	47	28.64(28.38)	54	32.49
Dermatology	10,663	231	0	40	170	21	69	0.81	187	69	36.90(34.18)	87	43.93
Urology	9,277	226	1	64	143	18	47	0.69	155	47	30.24(31.53)	52	34.91
Psychiatry	38,733	228	3	97	119	9	37	0.55	124	37	29.85(28.68)	46	36.75
Neurology	13,856	229	3	86	122	18	44	0.59	133	44	33.19(33.61)	49	37.20
Ophthalmology	17,198	227	1	46	168	12	66	0.79	177	66	37.20(38.08)	79	45.48
Otolaryngology	8,853	228	2	69	143	14	48	0.67	152	48	31.49(30.51)	57	36.17
All other specialties	156,088	431	9	218	177	27	66	0.45	189	66	34.90(33.90)	77	40.00

(1) Data are derived from the American Medical Association and the American Osteopathic Association and represent the total number of physicians who were eligible for the 2016 NAMCS sample.
(2) Respondents are physicians for whom at least one-half of their expected number of Patient Record forms were completed (full responders) and also include physicians who saw no patients during their sampled week. Response rate is the number of respondents divided by the estimated number of in-scope physicians.
(3) Participants are physicians for whom at least one Patient Record form was completed (full and minimal responders) and also include physicians who saw no patients during their sampled week. Participation rate is the number of participants divided by the estimated number of in-scope physicians.

Table 2. Number of physicians in the total sample, sample response categories, response rates, number of participants and participant rate by region: National Ambulatory Medical Care Survey, 2016

Region	Total (1)	Out of Scope and non-locatable	Out of Scope and locatable	In Scope	Eligibility Status Unknown	Respon-dents	Estimated Proportion for Unknown eligibility	Estimate of in Scope Physicians	Respon-dents	Response rates: unweighted (weighted) (2)	Partici-pants(3)	Participation rate: weighted (3)
Total	3,699	49	1,328	2,080	242	721	0.61	2,228	721	32.37(32.69)	1,030	45.97
Northeast	822	23	317	437	45	131	0.58	463	131	28.29(28.94)	211	45.21
Midwest	822	5	276	475	66	172	0.63	517	172	33.29(34.43)	221	43.14
South	1,233	13	490	657	73	261	0.57	699	261	37.35(40.03)	372	55.34
West	822	8	245	511	58	157	0.68	550	157	28.53(24.62)	226	36.75

NOTE: Regions represent location of sampling location.
(1) Data are derived from the American Medical Association and the American Osteopathic Association and represent the total number of physicians who are eligible for the 2016 NAMCS sample.
(2) Respondents are physicians for whom at least one-half of their expected number of Patient Record forms were completed (full responders) and also include physicians who saw no patients during their sampled week. Response rate is the number of respondents divided by the estimated number of in-scope physicians.
(3) Participants are physicians for whom at least one Patient Record form was completed (full and minimal responders) and also include physicians who saw no patients during their sampled week. Participation rate is the number of participants divided by the estimated number of in-scope physicians.

E. POPULATION FIGURES

The base population used in computing annual visit rates is presented in tables 3 and 4. The denominators used in calculating 2016 visit rates for age, sex, race, ethnicity, and geographic region are Census 2010-based postcensal estimates of the civilian noninstitutionalized population of the United States. The population estimates are special tabulations developed by the Population Division, U.S. Census Bureau, from the July 1, 2016 set of state population estimates by age, sex, race, and ethnicity.

Population estimates by metropolitan statistical area (MSA) status are based on estimates of the civilian noninstitutionalized population from the 2016 National Health Interview Survey (NHIS), National Center for Health Statistics, compiled according to the February 2013 Office of Management and Budget definition of core-based statistical areas. See http://www.census.gov/population/metro/data/pastmetro.html for more information about MSA definitions.

Estimates of visit rates for metropolitan and non-metropolitan statistical areas from 2003-2016 may differ somewhat from those reported in 2002 and previous years because of methodological differences in how the denominators were calculated. In survey years 1995-2005, NHIS used metropolitan areas as defined by the Office of Management and Budget, June 30, 1993. In survey years 1994-2002, NHIS used 1990-based Census estimates as controls. Because NAMCS used Census 2000-based population estimates beginning in 2001, adjustments needed to be made to the MSA figures obtained from NHIS in 2001 and 2002. For 2010-2015, special tabulations were obtained from the Office of Analysis and Epidemiology, NCHS, where each year of data was compiled according to the most recently available OMB definition of core-based statistical areas. The 2010 NHIS estimates were adjusted by AHCSB based on the 2010 population estimates obtained from the U.S. Census Bureau (which were based on Census 2000). For 2011-2015, the NHIS estimates were adjusted based on the annual population estimates obtained from the U.S. Census Bureau (which were based on Census 2010). For 2016, AHCSB staff produced MSA and non-MSA estimates using data from the 2016 NHIS compiled according to the OMB definition of core-based statistical areas as of July 2015. The estimates were also adjusted based on 2016 population estimates obtained from the U.S. Census Bureau.

Population estimates for race groups in the 2016 NAMCS are based on the 2010 U.S. Census in which respondents were able to indicate more than one race category. Since 2001, the denominators used for calculating race-specific visit rates in NAMCS reports reflect multiple-race reporting. Specific race denominators reflect persons with a single race identification, and a separate denominator is available for persons with more than one race designation.

Data indicate that multiple races are recorded for a patient less frequently in medical records compared to their numbers in the general population. The 2016 population estimates indicate that 2.6 percent of the total population identify themselves as being of multiple races. In contrast, multiple race patients account for just 0.2 percent of weighted NAMCS visits (based on known race data only). (REMINDER: Beginning with the 2009 NAMCS, NAMCS data only include imputed values for the race categories White, Black, and Other; see 2009 or 2010 NAMCS Public Use File Documentation Summary of Changes for more information.) This is roughly the same percentage reported in the 2015 NAMCS and earlier years. The difference may exist because abstractors are less likely to know and record multiple race preferences of patients. It suggests that the race population rates calculated for 2016 may be slight overestimates for the single race categories and slight underestimates for the multiple race category, but it should be kept in mind that race data are missing on the public use file for 27.7 percent (unweighted) and 29.2 percent (weighted) of 2016 NAMCS records overall.

Table 3. U.S. population estimates used in computing annual visit rates for the National Ambulatory Medical Care Survey, by age, race, and sex: July 1, 2016

Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All Races	318,015,317	3,968,361	15,953,212	41,009,146	42,543,060	43,452,079
Male	155,430,571	2,029,605	8,154,522	20,922,946	21,469,863	21,531,789
Female	162,584,746	1,938,756	7,798,690	20,086,200	21,073,197	21,920,290
White Only	245,007,209	2,840,050	11,412,835	29,815,407	31,319,831	32,348,240
Male	120,799,772	1,454,146	5,843,537	15,251,823	15,895,495	16,264,818
Female	124,207,437	1,385,904	5,569,298	14,563,584	15,424,336	16,083,422
Black Only	41,643,741	603,897	2,432,767	6,138,343	6,464,972	6,135,538
Male	19,475,347	307,313	1,233,737	3,108,460	3,181,713	2,860,810
Female	22,168,394	296,584	1,199,030	3,029,883	3,283,259	3,274,728
AIAN* Only	3,982,711	64,126	257,567	651,768	639,493	611,041
Male	1,986,369	32,612	130,979	331,054	321,958	312,483
Female	1,996,342	31,514	126,588	320,714	317,535	298,558
Asian Only	18,222,752	204,684	849,963	2,139,270	2,385,383	3,114,889
Male	8,658,580	104,919	435,575	1,082,010	1,200,683	1,497,156
Female	9,564,172	99,765	414,388	1,057,260	1,184,700	1,617,733
NHOPI*	749,917	12,451	49,233	119,961	112,551	131,939
Male	374,687	6,378	25,183	60,732	56,203	67,192
Female	375,230	6,073	24,050	59,229	56,348	64,747
Multiple Races	8,408,987	243,153	950,847	2,144,397	1,620,830	1,110,432
Male	4,135,816	124,237	485,511	1,088,867	813,811	529,330
Female	4,273,171	118,916	465,336	1,055,530	807,019	581,102

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

Geographic Region totals		Metropolitan Statistical Area totals	
Northeast	55,476,208	MSA	273,981,761
Midwest	66,957,107	Non-MSA	44,033,556
South	120,033,029		
West	75,548,973		

Table 3. U.S. population estimates used in computing annual visit rates for the National Ambulatory Medical Care Survey, by age, race, and sex: July 1, 2016 - con.

Race and sex	35-44	45-54	55-64	65-74	75+
All Races	39,660,646	42,270,974	41,208,341	28,404,298	19,545,200
Male	19,443,041	20,665,800	19,814,190	13,277,094	8,121,721
Female	20,217,605	21,605,174	21,394,151	15,127,204	11,423,479
White Only	30,046,378	33,195,187	33,419,644	23,831,385	16,778,252
Male	15,012,255	16,472,930	16,267,518	11,281,064	7,056,186
Female	15,034,123	16,722,257	17,152,126	12,550,321	9,722,066
Black Only	5,262,118	5,372,731	4,830,160	2,761,623	1,641,592
Male	2,374,498	2,446,643	2,184,042	1,181,757	596,374
Female	2,887,620	2,926,088	2,646,118	1,579,866	1,045,218
AIAN* Only	526,569	491,440	403,771	219,719	117,217
Male	266,119	244,454	193,917	103,575	49,218
Female	260,450	246,986	209,854	116,144	67,999
Asian Only	2,911,202	2,493,853	1,997,881	1,288,290	837,337
Male	1,354,783	1,160,565	904,033	570,024	348,832
Female	1,556,419	1,333,288	1,093,848	718,266	488,505
NHOPI*	107,790	90,625	68,812	37,095	19,460
Male	54,533	44,615	33,549	17,890	8,412
Female	53,257	46,010	35,263	19,205	11,048
Multiple Races	806,589	627,138	488,073	266,186	151,342
Male	380,853	296,593	231,131	122,784	62,699
Female	425,736	330,545	256,942	143,402	88,643

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

SOURCE: These are U.S. Census Bureau postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2016. The estimates of age, sex, race and region are from special tabulations developed by the Population Division, U.S. Census Bureau using the July 1, 2016 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

Table 4. U.S. population estimates used in computing annual visit rates for the National Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2016

HISPANIC Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All Races	56,809,443	1,024,912	4,119,012	10,286,683	9,422,836	8,852,613
Male	28,456,576	523,366	2,098,166	5,234,056	4,784,760	4,554,029
Female	28,352,867	501,546	2,020,846	5,052,627	4,638,076	4,298,584
White Only	49,955,229	868,617	3,501,025	8,864,365	8,232,131	7,757,549
Male	25,046,238	443,662	1,783,788	4,511,400	4,181,505	4,003,017
Female	24,908,991	424,955	1,717,237	4,352,965	4,050,626	3,754,532
Black Only	2,728,986	59,310	235,242	539,504	468,446	447,852
Male	1,325,412	30,314	119,777	273,937	237,951	216,759
Female	1,403,574	28,996	115,465	265,567	230,495	231,093
AIAN* Only	1,651,492	31,262	123,954	302,689	278,165	274,289
Male	854,960	15,867	62,928	154,170	141,569	148,298
Female	796,532	15,395	61,026	148,519	136,596	125,991
Asian Only	569,802	12,659	49,193	111,262	94,497	92,322
Male	281,685	6,448	24,975	57,056	47,332	45,663
Female	288,117	6,211	24,218	54,206	47,165	46,659
NHOPI*	201,605	4,261	16,622	38,273	32,827	36,883
Male	103,571	2,176	8,442	19,385	16,655	20,054
Female	98,034	2,085	8,180	18,888	16,172	16,829
Multiple Races	1,702,329	48,803	192,976	430,590	316,770	243,718
Male	844,710	24,899	98,256	218,108	159,748	120,238
Female	857,619	23,904	94,720	212,482	157,022	123,480

Table 4. U.S. population estimates used in computing annual visit rates for the National Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2016 - con.

HISPANIC Race and sex	35-44	45-54	55-64	65-74	75+
All Races	8,119,420	6,621,795	4,446,259	2,387,169	1,528,744
Male	4,103,963	3,315,429	2,146,623	1,082,636	613,548
Female	4,015,457	3,306,366	2,299,636	1,304,533	915,196
White Only	7,203,735	5,939,119	4,002,365	2,174,079	1,412,244
Male	3,652,780	2,982,098	1,934,174	986,294	567,520
Female	3,550,955	2,957,021	2,068,191	1,187,785	844,724
Black Only	366,963	276,004	185,748	94,931	54,986
Male	170,114	128,093	85,783	41,579	21,105
Female	196,849	147,911	99,965	53,352	33,881
AIAN* Only	245,180	192,556	121,906	54,191	27,300
Male	130,780	101,311	62,329	26,173	11,535
Female	114,400	91,245	59,577	28,018	15,765
Asian Only	79,987	60,802	39,336	19,171	10,573
Male	39,397	29,559	18,625	8,526	4,104
Female	40,590	31,243	20,711	10,645	6,469
NHOPI*	30,196	21,518	12,589	5,463	2,973
Male	16,033	10,899	6,158	2,575	1,194
Female	14,163	10,619	6,431	2,888	1,779
Multiple Races	193,359	131,796	84,315	39,334	20,668
Male	94,859	63,469	39,554	17,489	8,090
Female	98,500	68,327	44,761	21,845	12,578

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

SOURCE: These are U.S. Census Bureau postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2016. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2016 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

Table 4. U.S. population estimates used in computing annual visit rates for the National Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2016 – con.

NON-HISPANIC Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All Races	261,205,874	2,943,449	11,834,200	30,722,463	33,120,224	34,599,466
Male	126,973,995	1,506,239	6,056,356	15,688,890	16,685,103	16,977,760
Female	134,231,879	1,437,210	5,777,844	15,033,573	16,435,121	17,621,706
White Only	195,051,980	1,971,433	7,911,810	20,951,042	23,087,700	24,590,691
Male	95,753,534	1,010,484	4,059,749	10,740,423	11,713,990	12,261,801
Female	99,298,446	960,949	3,852,061	10,210,619	11,373,710	12,328,890
Black Only	38,914,755	544,587	2,197,525	5,598,839	5,996,526	5,687,686
Male	18,149,935	276,999	1,113,960	2,834,523	2,943,762	2,644,051
Female	20,764,820	267,588	1,083,565	2,764,316	3,052,764	3,043,635
AIAN* Only	2,331,219	32,864	133,613	349,079	361,328	336,752
Male	1,131,409	16,745	68,051	176,884	180,389	164,185
Female	1,199,810	16,119	65,562	172,195	180,939	172,567
Asian Only	17,652,950	192,025	800,770	2,028,008	2,290,886	3,022,567
Male	8,376,895	98,471	410,600	1,024,954	1,153,351	1,451,493
Female	9,276,055	93,554	390,170	1,003,054	1,137,535	1,571,074
NHOPI*	548,312	8,190	32,611	81,688	79,724	95,056
Male	271,116	4,202	16,741	41,347	39,548	47,138
Female	277,196	3,988	15,870	40,341	40,176	47,918
Multiple Races	6,706,658	194,350	757,871	1,713,807	1,304,060	866,714
Male	3,291,106	99,338	387,255	870,759	654,063	409,092
Female	3,415,552	95,012	370,616	843,048	649,997	457,622

Table 4. U.S. population estimates used in computing annual visit rates for the National Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2016 - con.

NON-HISPANIC Race and sex	35-44	45-54	55-64	65-74	75+
All Races	31,541,226	35,649,179	36,762,082	26,017,129	18,016,456
Male	15,339,078	17,350,371	17,667,567	12,194,458	7,508,173
Female	16,202,148	18,298,808	19,094,515	13,822,671	10,508,283
White Only	22,842,643	27,256,068	29,417,279	21,657,306	15,366,008
Male	11,359,475	13,490,832	14,333,344	10,294,770	6,488,666
Female	11,483,168	13,765,236	15,083,935	11,362,536	8,877,342
Black Only	4,895,155	5,096,727	4,644,412	2,666,692	1,586,606
Male	2,204,384	2,318,550	2,098,259	1,140,178	575,269
Female	2,690,771	2,778,177	2,546,153	1,526,514	1,011,337
AIAN* Only	281,389	298,884	281,865	165,528	89,917
Male	135,339	143,143	131,588	77,402	37,683
Female	146,050	155,741	150,277	88,126	52,234
Asian Only	2,831,215	2,433,051	1,958,545	1,269,119	826,764
Male	1,315,386	1,131,006	885,408	561,498	344,728
Female	1,515,829	1,302,045	1,073,137	707,621	482,036
NHOPI*	77,594	69,107	56,223	31,632	16,487
Male	38,500	33,716	27,391	15,315	7,218
Female	39,094	35,391	28,832	16,317	9,269
Multiple Races	613,230	495,342	403,758	226,852	130,674
Male	285,994	233,124	191,577	105,295	54,609
Female	327,236	262,218	212,181	121,557	76,065

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

SOURCE: These are U.S. Census Bureau postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2016. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2016 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

F. FIELD ACTIVITIES

The U.S. Census Bureau acts as the data collection agent for NAMCS. The first contact with the sample physician is through a letter from the Director, NCHS. After the physician receives the introductory letter (along with letters from professional medical societies which endorse NAMCS), the Census Field Representative (FR) telephones the physician to establish basic eligibility and to schedule an appointment. At the appointment, the FR explains the survey to the physician and to any staff who may be involved in abstracting the data. Also at the initial visit, the FR obtains the practice characteristics of up to five office locations (expanded from four in 2011) where the physician sees patients during the reporting week. After abstraction has been completed, the physician is given a certificate of appreciation for her or his participation.

G. DATA COLLECTION

The 2016 NAMCS utilized two methods of data collection. The first mode, which accounted for the majority of sampled records, involved the abstraction of medical records by U.S. Census Bureau field staff.

Physicians were instructed to keep a daily listing of all patient visits during the assigned reporting week using an arrival log, optional worksheet, or similar method. This list was the sampling frame to indicate the visits for which data were to be recorded. It was to include both scheduled and unscheduled patients, but not cancellations or no-shows. Visits were selected from the list using a random start and a predetermined sampling interval based on the physician's estimated visits for the week and the number of days the physician was expected to see patients that week. In this way, a systematic random sample of visits was obtained. The sampling procedures were designed so that about 30 electronic Patient Records would be completed during the assigned reporting week. This was intended to minimize the data collection workload and maintain equal reporting levels among sample physicians regardless of practice size.

Data for sampled visits were recorded on laptops. The 2016 Patient Record "Sample Card" showing the data items included in the survey is available at the Ambulatory Health Care Data website: http://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm#namcs. Terms and definitions relating to the automated Patient Record are included in Appendix I.

The second mode of data collection was the first attempt by NCHS to collect data directly from electronic health records. A total of 585 physicians who had used NCHS's National Health Care Surveys Registry (https://www.cdc.gov/nchs/dhcs/nhcs_registry_landing.htm) to register their intent to participate in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Programs: Promoting Interoperability (PI) (formerly known as Meaningful Use), and the Merit-based Incentive Payment System (MIPS) were included in this mode. These 585 physicians were also in the NAMCS sample frame.

The Registry allows physicians to participate in specialized or public health reporting through electronic data submission in order to comply with CMS program goals. In order to participate, they agreed to submit EHR data directly to NCHS. However, the EHR data require harmonizing with the abstracted data, and this process has been subject to many technical challenges. In order to release 2016 data more quickly, the current public use file only includes abstracted data. Physicians with only EHR data are treated as non-respondents for purposes of the current file release.

H. CONFIDENTIALITY

In April 2003, the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) was implemented to establish minimum Federal standards for safeguarding the privacy of individually identifiable health information. No personally identifying information, such as patient's name or address or Social Security number, is collected in NAMCS. Data collection is authorized by Section 306 of the Public Health Service Act (Title 42, U.S. Code, 242k). All information collected is held in the strictest confidence according to law [Section 308(d) of the Public Health Service Act (42, U.S. Code, 242m(d))] and the Confidential Information Protection and Statistical Efficiency Act (Title 5 of PL 107-347). The NAMCS protocol has been approved by the NCHS Research Ethics Review Board annually starting in February 2003. Waivers of the requirements to obtain informed consent of patients and patient authorization for release of patient medical record data by health care providers were granted.

In the spring of 2003, NAMCS implemented additional data collection procedures to help providers assure patient confidentiality. Census Bureau Field Representatives were trained on how the Privacy Rule allows physicians to make disclosures of protected health information without patient authorization for public health purposes and for research that has been approved by a Research Ethics Review Board. Physicians were encouraged to accept a data use agreement between themselves and NCHS, since the Privacy Rule allows physicians to disclose limited data sets (i.e., data sets with no direct patient identifiers) for research and public health purposes if such an agreement exists.

Assurance of confidentiality was provided to all physicians according to Section 308 (d) of the Public Health Service Act (42 USC 242m). Strict procedures were utilized to prevent disclosure of NAMCS data. All information which could identify the physician was confidential and was seen only by persons engaged in NAMCS, and was not disclosed or released to others for any other purpose. Names or other identifying information for individual patients were not removed from the physician's office.

Prior to release of the public use data file, NCHS conducts extensive disclosure risk analysis to minimize the chance of any inadvertent disclosure. Based on research conducted by NCHS for 2016 NAMCS, certain variables were subject to masking in some cases (patient race, whether visit occurred in a metropolitan statistical area, is physician a medical doctor or doctor of osteopathy, is physician in solo or group practice, physician's diagnosis, and medication). Furthermore, outlier values for certain variables (age, age of pregnant patient, height, weight, number of past visits in last 12 months, and time spent with physician) were top coded in accordance with NCHS confidentiality requirements. Masking was performed in such a way to cause minimal impact on the data; data users who wish to use unmasked data can apply to the NCHS Research Data Center.

I. DATA PROCESSING

1. Edits

Once electronic data were collected, a number of steps were required for data processing. Specifications for checking, configuring, and transmitting the data files were developed by NCHS and applied by the Census Bureau. Data files were transmitted either to NCHS for further processing, or to RTI International, Research Triangle Park, North Carolina. At NCHS, the data underwent multiple consistency checks and review of verbatim entries. RTI edited and coded verbatim entries which required medical coding (patient's reason for visit, physician's diagnosis, cause of injury, services, and procedures) and further assessed the values assigned to a variable that indicated whether the diagnosis is probable, questionable, or rule out. Medication editing and coding were performed entirely at NCHS by the NAMCS Drug Database Coordinator.

2. Quality Control

All RTI International medical coding and keying operations were subject to quality control procedures. The contractor selected an 11.6 percent sample of records which were independently recoded and compared.
Differences were adjudicated by RTI with error rates reported to NCHS. Coding error rates ranged between 0.03 and 0.8 percent.

3. Adjustments for Item Nonresponse

Unweighted item nonresponse rates exceeded 5.0 percent for the following data items:

Variable	Variable Description	Denominator	Nonresponse %
PREGNANT	Is patient pregnant?	All visits by females ages 12-50	11.0
GESTWK	Gestation week	All visits by pregnant females	34.4
ETHUN	Patient ethnicity - unimputed	All visits	25.6
RACEUN	Patient race – unimputed	All visits	27.7
PAYTYPER	Type of payment (recoded from multiple sources using hierarchy)	All visits	6.0
USETOBAC	Current tobacco use	All visits	18.4
EVERTOBAC	Former tobacco user	All visits	37.2
INJURY, INJPOISAD	Is visit related to injury/trauma, overdose/poisoning or adverse effect of medical/surgical treatment?	All visits	5.1
INJURY72	Did the injury/trauma, overdose/ poisoning or adverse effect occur within 72 hours prior to the date and time of this visit?	All injury visits	47.9
INJURY_ENC	Type of encounter for injury visit	All injury visits	19.5
CAUSE1	Cause of Injury #1	All injury visits	43.0
TEMPF	Temperature (in Fahrenheit)	All visits	69.7
HTIN	Height (in inches)	All visits	38.8
WTLB	Weight (in pounds)	All visits	32.1
BMI	Body mass index - calculated from height and weight	All visits	41.9
BPSYS	Systolic blood pressure	All visits	42.0
BPDIAS	Diastolic blood pressure	All visits	42.1
REFER	Was patient referred for visit?	All visits not made to patient's primary care provider	15.2
PASTVIS	How many past visits in the last 12 months?	All visits by established patients	13.9

EXCIPROV	Excision of tissue provided	All visits where excision was reported	45.7
BIOPROV	Biopsy provided	All visits where biopsy was reported	20.4
NCMED28	Is Medication #28 new or continued	All visits where applicable medication was ordered or prescribed	7.7
NCMED29	Is Medication #29 new or continued	All visits where applicable medication was ordered or prescribed	12.5
TIMEMD	Time spent with physician	All visits where a physician was seen	33.3
A1C	Was blood for HbA1c test drawn at visit or within past 12 months?	Visits for selected specialties	10.7
FBG	Was blood for blood glucose (BG) drawn at visit or within past 12 months?	Visits for selected specialties	10.4
TGS	Was blood for triglycerides (TGS) test drawn at visit or within past 12 months?	Visits for selected specialties	10.1
SERUM	Was blood for serum creatinine drawn at visit or within past 12 months?	Visits for selected specialties	10.1
CHOL	Was blood for total cholesterol test drawn at sampled visit or within past 12 months?	Visits for selected specialties	10.1
HDL	Was blood for HDL test drawn at visit or within past 12 months?	Visits for selected specialties	10.0
LDL	Was blood for LDL test drawn at visit or within past 12 months?	Visits for selected specialties	9.8
HOSVISR	During last normal week of practice, did you make any hospital visits?	All visits	5.7
TELCONR	During last normal week of practice, did you have any telephone consults with patients?	All visits	5.7
EREMINDR	Does reporting location have this computerized capability: providing reminders for guideline-based interventions or screening tests?	All visits	5.1
EGENLISTR	Does reporting location have this computerized capability: providing data to generate lists of patients with particular health conditions?	All visits	6.0
EDATAREPR	Does reporting location have this computerized capability: providing data to create reports on clinical care measures for patients with specific chronic conditions (e.g. HbA1c for diabetics)?	All visits	8.3
ESHARES	Do you electronically send patient health information to another provider whose EHR system is different from your own?	All applicable visits	9.4
ESHARER	Do you electronically receive patient health information from another provider whose EHR system is different from your own?	All applicable visits	8.8
PRMCARER	Percent of patient care revenue from Medicare	All visits	16.2
PRMAIDR	Percent of patient care revenue from	All visits	16.2

	Medicaid		
PRPRVTR	Percent of patient care revenue from private insurance	All visits	16.0
PRPATR	Percent of patient care revenue from patient payments	All visits	16.0
PROTHR	Percent of patient care revenue from other sources	All visits	16.0
PRMANR	Percent of patient care revenue from managed care contracts	All visits	23.3
REVFFSR	Percent of patient care revenue from fee-for-service	All visits	28.0
REVCAPR	Percent of patient care revenue from capitation	All visits	28.0
REVCASER	Percent of patient care revenue from case rates	All visits	28.0
REVOTHR	Percent of patientcare revenue from other	All visits	28.0
PRIVATE	Type of payments accepted from new patients: capitated or non-capitated private insurance	All visits from providers that currently accept "new" patients	5.5
CAPITATE	Type of payments accepted from new patients: capitated private insurance	All visits from providers that currently accept "new" patients	8.6
NOCAP	Type of payments accepted from new patients: non-capitated private insurance	All visits from providers who currently accept "new" patients	6.5
NNOCHRGE	Type of payments accepted from new patients: no charge/charity	All visits from providers who currently accept "new" patients	7.3
PHYSCOMP	Which of the following methods best describes your basic compensation?	All visits	7.0
SDAPPTPCT	What percentage of your visits are same day appointments?	All visits where physicians responded ‘yes’ to “Does your practice set time aside for same day appointments?”	24.9

Denominators for the above rates were adjusted to account for skip patterns on the data collection forms. For example, only visits to physicians who accepted new patients were included in the calculation of whether the physician accepted new patients with Medicaid, etc. Physician nonresponse to the initial item may also be taken into account, which would make nonresponse rates for the secondary item somewhat higher. Nonresponse is calculated to include blanks, abstractor responses of unknown, and physician’s refusal to answer.

IMPORTANT: For items such as vital signs (patient height and weight, etc.), nonresponse rates are calculated for all visits, but it should be considered that such measurements are not routinely taken or

reported at visits to certain specialties, such as psychiatry or dermatology among others. It is advisable for researchers to calculate their own nonresponse rates for their topic of interest; these rates are only provided as a general indicator.

Some missing data items were imputed by randomly assigning a value from a PRF with similar characteristics, where similar visits were generally those with the same physician specialty, geographic region, and 3-digit ICD-10-CM code for primary diagnosis. Race and ethnicity were imputed using a model-based, single, sequential regression imputation method. The model for imputing race and ethnicity used the following variables: Census race and ethnicity population estimates for ZIP code, duration of visit, patient age, patient sex, whether the visit occurred in an MSA, physician specialty recode, whether the visit included hypertension as a current diagnosis/chronic condition, diagnosis group, major reason for visit, and an indicator for patient ZIP code or provider ZIP (the latter was used for the Census variables if patient ZIP was not available). Also in 2016, time spent with physician was imputed using a similar model-based, single, sequential regression imputation method.

The following variables were imputed: birth year (<0.1 percent), sex (0.6 percent), ethnicity (25.6 percent), race (27.7 percent), has the patient been seen in this practice before? (0.9 percent), if yes, how many past visits in last 12 months? (13.9 percent of visits by established patients), and time spent with physician (33.3 percent of visits where a physician was seen). Blank or otherwise missing responses are so noted in the data.

J. MEDICAL CODING

The PRF contains several medical items which use three separate coding systems. As stated previously, the following items -- patient's reason for visit (RFV1-RFV5), physician's diagnosis (DIAG1-DIAG5), cause of injury (CAUSE-CAUSE3), and procedures (PROC1-PROC9) -- were transmitted to RTI International, Inc., Research Triangle Park, North Carolina for processing. Responses to the medication item (MED1-MED30) were coded by the NAMCS Drug Database Coordinator. These items and their coding systems are described briefly below.

1. Patient's Complaint(s), Symptoms(s) or Other Reason(s) for this Visit

Information on patient's reason for visit was collected in the automated Patient Record and coded according to A Reason for Visit Classification for Ambulatory Care (RVC) (7). The most recent classification can be found in Appendix II. The classification is updated as needed to incorporate new codes as well as changes to existing codes. The system continues to utilize a modular structure. The digits 1 through 8 precede the 3-digit RVC codes to identify the various modules as follows:

Prefix	Module
"1" =	Symptom module
"2" =	Disease module
"3" =	Diagnostic, screening, and preventive module
"4" =	Treatment module
"5" =	Injuries and adverse effects module
"6" =	Test results module
"7" =	Administrative module
"8" =	Uncodable entries
"9" =	Special code = blank

Up to five reasons for visit were coded from the reason for visit item in sequence; coding instructions for this item are contained in the Reason for Visit Classification and Coding Manual (8).

2. Cause of Injury/Trauma, Overdose/Poisoning, or Adverse Effect of Medical/Surgical Treatment

Up to three causes of injury/trauma, overdose/poisoning, or adverse effect were coded from text responses to the "Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment" section in the Injury item on NAMCS PRFs. NCHS contracted medical coders used the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) (2) to code the responses. Unlike the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (3), which included the Supplementary Classification of External Causes of Injury and Poisoning (E-codes), ICD-10-CM used additional chapters of codes starting with the letters V, W, X, and Y to describe external causes of injury.

For the NAMCS public use file, only the first four digits of the ICD-10-CM 7-digit cause of injury code are included. There is a separate item added to indicate the encounter status normally found in the 7th position for initial episode of care for the injury, subsequent episode of care for the injury, or sequela of the injury. There is an implied decimal between the third and fourth digits and inapplicable 4th digits are dash-filled.

Examples: V011 = V01.1 Pedestrian injured in collision with pedal cycle in traffic accident.
W14- = W14 Fall from tree

Because ICD-10-CM incorporates many alphabetic characters into their expanded list of codes, we can no longer provide numeric recodes for the cause of injury fields.

3. Provider's Diagnosis

Up to five diagnoses were coded in sequence from text responses to the "Diagnosis" item on the NAMCS PRF. NCHS contracted medical coders used the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) to code the responses. Coding instructions for diagnoses are contained in the NAMCS Coding Requirements Manual (9).

In ICD-10-CM, diagnosis codes can have a maximum of seven digits. ICD-10-CM organizes these codes within chapters from A to T. The Z chapter is used to assign codes for occasions that are not related to a current illness or injury.

For the NAMCS public use file, only the first four digits of the diagnosis code1 are included. There is an implied decimal between the third and fourth digits and inapplicable 4th digits are dash-filled. For example:

F321 = F32.1 Major depressive disorder, single episode, moderate
I10- = I10 Essential (primary) hypertension
Z992 = Z99.2 Dependence on renal dialysis

In addition to the diagnosis codes from the ICD-10-CM the following unique codes in the diagnosis fields were developed by NAMCS staff:

ZZZ0 = noncodable diagnosis, insufficient information for coding, illegible diagnosis
ZZZ1 = left before being seen, walked out, eloped, left against medical advice
ZZZ2 = discharge dispositions entered such as "return to nursing home", "transfer to nursing home", "transfer to psychiatric hospital", "transfer to other hospital", sent to see specialist, referred
ZZZ3 = Insurance/HMO will not authorize treatment

ZZZ4 = Entry of "none," "no diagnosis," "no disease," "healthy" as the ONLY entry in the diagnosis item
ZZZ5 = Entry of “NA”, “Not Available”, “Not Applicable” or “Blank”.
-9 = Field is blank (in contrast to an actual entry of “Blank”)

As mentioned above, because ICD-10-CM uses non-numeric characters so extensively, we are no longer able to provide numeric recodes for the character format codes.

4. Services

The “Services” item used a checkbox format under the sub-headings of Examinations/Screenings, Laboratory tests, Imaging, Procedures, Treatments, and Health Education/Counseling. It also allowed for text to be entered under “Other Services Not Listed”. Up to 9 procedures could be coded from the verbatim text entries. RTI International, Research Triangle Park, North Carolina classified and coded the verbatim text using the ICD-10-CM/PCS (Procedure Classification System) (4).

The structure of ICD-10-CM/PCS is very different than the procedure codes in ICD-9-CM, Volume 3, Procedure Classification, which had been used to code NAMCS procedure data in previous years. ICD-10-CM/PCS codes are maintained by the Centers for Medicare and Medicaid Services and include up to 7 alphanumeric digits, which reflect the broad procedure type (e.g., medical and surgical), the larger body system (e.g., lymphatic and hemic systems), root operation (e.g., drainage), body part (e.g., spleen), approach (e.g., open), device (e.g., drainage device) and a qualifier (e.g., diagnostic). There are nearly 19 times as many procedure codes in ICD-10-CM/PCS than in ICD-9-CM, Volume 3.

The added detail required to correctly code verbatim fields is not always present in NAMCS data. Especially with the procedure data, many of the resulting codes do not include all of the 7 dimensions listed above. For example, some sample SAS output for PROC1 (first-listed procedure), shown below without format labels, looks like this:

PROC1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
085E3ZZ	1	0.15	465	68.69
085_3ZZ	1	0.15	466	68.83
085__ZZ	1	0.15	467	68.98
08J_XZZ	2	0.30	469	69.28

The first code shown is fully coded and represents these dimensions: 0 (Medical and Surgical), 8 (Eye), 5 (Destruction), E (Retina, right), 3 (Percutaneous), Z (No device), Z (No qualifier). This translates to a code title of “DESTRUCTION OF RIGHT RETINA, PERCUTANEOUS APPROACH”, which would be displayed when using the SAS or SPSS procedure formats. However, the next 3 codes were unable to be fully coded based on the available data. Two of them are missing the 4th dimension (body part), and one of them is missing both the 4th and 5th dimensions. When information was not available to coders, an underscore was inserted. Labels for each code are only available from ICD-10-CM/PCS when the full code is known. Where codes are incomplete, custom labels were developed by NCHS to provide as much detail as possible. These display in the output starting with the text “CODE LACKING SPECIFICITY, LABEL REPRESENTS [ ]” with whatever information can be given.

The number of checkboxes for the SERVICES item has increased over the years. This measure was intended to facilitate reporting and reduce costs associated with medical coding of text entries. The result of this change is a decrease in the number of visits with write-in procedures, with some resulting loss of detail.

Efforts were made to ensure that text entries which could be coded to checkboxes were also coded that way, in order for the checkbox data to give the most inclusive estimate. For example, records where the verbatim text was coded to “Ultrasound of the Left Eye” also have the “Other Ultrasound” checkbox checked. The guidelines for the Services item have traditionally been that procedure codes which could be coded to checkboxes were retained if they provided additional detail about the procedure beyond what was available in the checkbox. Researchers should be careful to compare data in the checkboxes with the procedure write-in data to ensure that they do not doublecount procedures.

5. Medications & Immunizations

The NAMCS drug data collected under “Medications & Immunizations” have been classified and coded using the entry name (the entry made on the Patient Record) according to a unique classification scheme developed at NCHS (10). The medical classification system of drugs by entry name uses a five-digit coding scheme which is updated
regularly to include new products. It includes the following special codes:

-9 = blank
99980 = unknown entry, other
99999 = illegible entry

For 2016, up to 30 medications could be recorded for each visit. A list of drug codes by entry name is included in Appendix III.

In addition to drugs coded by entry name, this file contains the following drug information:

a. Generic drug code: Beginning with the 2006 data release, drugs are coded in terms of their generic components and therapeutic classifications using Lexicon Plus®, a proprietary database of Cerner Multum, Inc., also used by the National Health and Nutrition Examination Survey, NCHS. The Lexicon Plus is a comprehensive database of all prescription and some nonprescription drug products available in the U.S. drug market.

In accordance with the license agreement, NCHS publications, tabulations, and software applications should cite the Multum Lexicon as the source and basis for the coding and classification of NAMCS drug data. For additional information on the Multum Lexicon Drug Database, please refer to the following Web site: http://www.cerner.com/multum_solutions/.

Beginning with the 2006 data release, all drug codes based on entry name (using NCHS’ classification system as cited above) were also assigned a unique generic drug code from Multum’s Lexicon Drug Database, whenever possible. The structure of the Multum database is such that multiple ingredient drugs are assigned a single generic drug code encompassing all of a drug's ingredients rather than being assigned generic drug codes for each ingredient, as in past years of NAMCS drug data.

For example, prior to 2006, if Tylenol No. 3 was reported in NAMCS, it was assigned a drug entry code of 32920 to reflect the entry of Tylenol No. 3. Using the NCHS generic classification, it was also given a code of 51380 in the generic code field to represent a combination product, and then received separate ingredient codes for acetaminophen and codeine. Under Multum, there is a single generic code that reflects the combination of acetaminophen with codeine.

The format of the generic drug code (now called DRUGID rather than GEN) also changed starting in 2006. Rather than the 5 digit numeric code used prior to 2006, the generic drug code is 6 digits, beginning with the letters “a”, “c” or “d”. Codes beginning with the letter “n” were also used, starting with 2009 data. All Multum codes begin with the letter “d”, but there were some drug names reported

by NAMCS participants that were not found in the Lexicon Drug Database. These were assigned unique drug codes beginning with an “a” where a drug’s ingredients could be determined, or a “c” in the case where a drug’s ingredients could not be determined for 2006-2007. Beginning with 2008 data, “n” codes have been used to code all drugs newly appearing in the NAMCS data for which a code could not be found in Multum. The variables DRUGID1 through DRUGID30 reflect the generic codes for each drug reported.

b. Prescription status code: A code designed to identify the legal status (prescription or nonprescription) of the drug entry.

c. Controlled substance status code: A code used to denote the degree of potential abuse and federal control of a drug entry.

d. Composition status code: A code used to distinguish between single-ingredient and combination drugs.

e. Therapeutic category code: In data years prior to 2006, a 4-digit code was used to identify up to three therapeutic classes to which the drug entry might belong. These were based on the standard drug classifications used in the National Drug Code Directory, 1995 edition (11).

However, as mentioned above, Multum’s therapeutic classification system is now being used. The Multum Lexicon provides a 3-level nested category system that assigns a therapeutic classification to each drug and each ingredient of the drug (e.g., for naproxen: the broadest category is central nervous system agents [level 1]; the more detailed category is analgesics [level 2]; and the most detailed category is nonsteroidal anti-inflammatory agents [level 3]). Not all drugs have three classification levels; some may only have two [e.g. for digoxin: cardiovascular agents [level 1]; inotropic agents [level 2]), others only have one. See Appendix III for the complete Multum category scheme.

Each drug may have up to four therapeutic categories on the data file. The variables RX1CAT1 through RX30CAT4 reflect the unique Multum drug categories for a particular drug; these are character values with codes from ‘001’ through ‘464’. **This variable will always show the most detailed therapeutic level available of a particular drug.**

For example, psychotherapeutic agents in Multum are further classified into a second more detailed level as antidepressants or antipsychotics. Antidepressants are further classified into seven subcategories (miscellaneous antidepressants, SSRI antidepressants, tricyclic antidepressants, monoamine oxidase inhibitors, phenylpiperazine antidepressants, tetracyclic antidepressants, and SSNRI antidepressants); antipsychotics are further classified into five subcategories. For a drug categorized as a tricyclic antidepressant, it would have a drug category code of ‘209’, reflecting the Level 3 code.

Other drugs may have only two levels available, such as immunologic agents. There are six level 2 categories of immunologic agents, and no further breakdowns into a third level in the Multum system. Therefore, RX1CAT1 would reflect only a second level code in that case. So, using RX1CAT1-RX30CAT4 will allow one to identify the most specific level of a drug, but **will not, by itself, identify whether that code reflects the first, second, or third level.**

In order to understand each level in terms of the Multum hierarchy, we have also placed on the file additional variables that show the full first, second, and third levels, if applicable, for each drug category for each drug. For example, in the case of the tricyclic antidepressant mentioned earlier, RX1CAT1=’209’. But there are three additional variables corresponding to that drug’s first therapeutic category. RX1V1C1 (meaning Drug 1, Level 1 of Therapeutic Category 1) would be ‘242’ (psychotherapeutic agents), RX1V2C1 (Drug 1, Level 2 of Therapeutic Category 1) would be ‘249’

(antidepressants), and RX1V3C1 (Drug 1, Level 3 of Therapeutic Category 1) would be '209' (tricyclic antidepressants). If there were no second or third level for a particular category, the entry would be blank (' '). This is repeated for each of the drug's maximum of four therapeutic categories. The three levels can easily be concatenated by data users if they wish to obtain a complete code showing the full level structure applicable to each drug's therapeutic categories. An advantage of having separate levels is that it allows data users to aggregate drugs at any level desired. SAS code is provided at the website for micro-data users who wish to group therapeutic categories in various ways.

All drugs were coded using Multum drug categories, even those drugs not found in Multum's drug database. "Unspecified" drugs were assigned to their respective therapeutic category (e.g., hormones – unspecified: category id=97, category name=hormones/hormone modifiers). Drugs that could not be assigned to any drug entry name (MED1-30 = 99980, 99999) were put in an NCHS-defined miscellaneous category.

In some cases, NCHS was able to categorize a drug's therapeutic class at the first or second Multum level, but not at the more detailed level. When this occurred, the undetermined levels are designated as '999' in the data.

As mentioned above, Multum uses a "combination" category for some multiple ingredient drugs. These include antihypertensive combinations, antiasthmatic combinations, upper respiratory combinations, psychotherapeutic combinations, bronchodilator combinations, sex hormone combinations, skeletal muscle relaxant combinations, and narcotic analgesic combinations. This categorization may be sufficient for certain analyses but not for others because it lacks information about the therapeutic effect of the individual ingredients that make up the combination. For example, the drug HYDROCHLOROTHIAZIDE; LOSARTAN is identified as an antihypertensive combination.

Therefore, we know that this drug has an antihypertensive drug effect. However, based on this combination category we do not know that the drug's single ingredients have the therapeutic effects of a diuretic and angiotensin II inhibitor, which is relevant for some analyses.

As a result, NCHS decided that, in addition to assigning therapeutic categories to each drug, a separate file would be provided listing the ingredients for each drug along with the therapeutic classes for each ingredient. In the case of single ingredient drugs, the ingredient therapeutic categories would be the same as the drug therapeutic categories. This separate downloadable file (the current version is DRUG_INGREDIENTS_2016 and can be found under the "DRUGS" folder in the Downloadable Documentation section of the website: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/drugs/) can be matched to the main file using the DRUGID code. For each DRUGID on the main file, the supplemental file contains up to 5 ingredients and up to 3 therapeutic category codes for each ingredient. Prior to 2006, codes used to identify the active generic ingredients of combination drugs were included on the regular public use file.

IMPORTANT: For 2016, we have continued to update and revise the drug characteristics in our ambulatory care drug database. This database has undergone many changes over the years. From 2002-2005, each drug entry had up to three therapeutic classes associated with it, compared with a single therapeutic class in prior years. These factors made trend analysis more problematic, and the solution was to provide researchers with a Drug Characteristics file, which was updated annually, at our website. The characteristics from this file (prior to Multum adoption) could be applied by matching on drug codes to previous years of data in order to get the most accurate results when doing analysis of drug trends. A SAS program for applying drug characteristics from the then-current drug database to previous years of NAMCS data was also made available for downloading. These files are all still available on the NAMCS website, but are mainly of use only if the researcher is limiting analysis to years of data prior to 2006 and wishes to retain the old National Drug Code Directory therapeutic categories.

Starting with the 2006 survey, however, with the adoption of the Multum Lexicon for coding drugs according to generic ingredients and therapeutic categories, a new solution for trend analysis was necessary. Therefore, along with the 2006 data file release, we provided a separate downloadable mapping file (MEDCODE_DRUGID_MAP_2006), which allows data users to match all of the drug codes used in previous years (for example, MED1-MED8 in 2005) with the corresponding Multum DRUGID code for generic composition of the drug and its corresponding therapeutic categories. Once that has been accomplished, users can also, if they wish, match to the drug ingredient file as described above. The mapping file was updated annually through 2012, but, because of resource limitations, has not been produced since then. The files can be downloaded at: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/drugs/. Researchers should keep in mind, however, that in cases where drug characteristics have legitimately changed over the years (e.g., moving from prescription to non-prescription status), using the current updated version of the drug characteristics will overwrite all of the previous characteristics with current ones.

For users who are interested in analyzing drug data, one method involves the isolation of those records with drugs, or drug mentions, and the creation of a separate data file of drug mentions. Each PRF can have up to 30 drug mentions recorded, so whatever file is created would need to include all of them. This method can be used for obtaining estimates of drug mentions, but is not recommended for variance estimation. Rather, the structure of the visit file should be kept intact when estimating variance. In order to do this, estimates of drug mentions can be obtained by creating a new weight variable (called DRUGWT in this example). This variable is created by multiplying PATWT (the patient visit weight) by NUMMED (the number of medications recorded at the sampled visit) or DRUGWT=PATWT*NUMMED. DRUGWT can then be used in place of PATWT to weight one's data; it produces the estimated number of drug mentions rather than visits. (See Codebook section for more on PATWT and NUMMED.)

This documentation contains some marginal data for drug mentions. Also provided are drug coding lists in Appendix III. To facilitate searching for drugs in Appendix III, it is recommended that researchers utilize the online search function in Adobe Acrobat with the pdf document, or visit the survey website and use the online drug database under Research Tools (http://www.cdc.gov/nchs/ahcd/ahcd_database.htm). Should the data user need additional assistance in analyzing data on drug mentions, the staff of the Ambulatory and Hospital Care Statistics Branch is available. See page 2 for Contact Information. Our website can be accessed at: http://www.cdc.gov/nchs/namcs.htm

K. ESTIMATION PROCEDURES

Statistics produced from the 2016 NAMCS were derived by a multistage estimation procedure. The procedure produces essentially unbiased national estimates and has four components: 1) inflation by reciprocals of the selection probabilities, 2) adjustment for nonresponse, 3) a ratio adjustment to fixed totals, and 4) weight smoothing. Each of these components is described below.

1. Inflation by Reciprocals of Sampling Probabilities

Because the survey utilized a two-stage sample design starting in 2012, there were two probabilities:

a) the probability of selecting a physician within a stratum
b) the probability of selecting a patient visit within the physician's practice

The strata used for the first probability were determined by sampling strata defined by physician specialty and geographical areas defined by the four Census regions. The second probability was defined to be the number of PRFs completed divided by the exact number of office visits during the physician's specified reporting week. To derive annual estimates, all weekly estimates were inflated by the number of weeks annually in which the physician typically sees patients in his/her practice.

2. Adjustment for Nonresponse

For the 2016 NAMCS, estimates were adjusted to account for 242 physicians whose eligibility for NAMCS remained unknown when data collection was completed. The NAMCS visit estimates were also adjusted to account for in-scope physicians who did not provide abstracted PRFs (non-PRF physicians) either because they saw no patients during their sample week or failed to provide abstracted PRFs for visits by patients they did see during their sample week. NAMCS eligible physicians who submitted only electronic health records for their visits were treated as non-respondents in the current estimates. For 2016, these adjustments account for nonresponse within physician practice type (primary care, surgical specialty, or medical specialty), and region.

Beginning with 2004 data, changes were made to the nonresponse adjustment factor to account for the seasonality of the reporting period. Weights for nonresponding physicians were shifted to responding physicians in reporting periods within the same seasonal quarter of the year if there was a sufficient response level within every quarter period. The shift in nonresponse adjustment did not significantly affect any of the overall annual estimates.

Beginning with 2003 data, the adjustment for non-PRF physicians differs from the adjustment used in prior years. This is described in more detail here. The 2003 weight with the revised nonresponse adjustment increased the overall visit estimate by 12 percent over the same estimate obtained using the original weight. For this reason, 2003 and subsequent year visit estimates are not entirely comparable to visit estimates computed using the previous weighting strategy. If researchers are presenting data with estimates or rates across these years, we recommend including a footnote such as the following: “The weights for 2003 and later years include adjustments for variation in the typical number of weeks worked annually and for variation in visit volume in a work week, whereas the weights for earlier years do not. The revised weighting algorithm increased visit estimates.”

3. Ratio Adjustment

A post-ratio adjustment was made within each of the physician specialty groups and region sampling strata to adjust for changes in the physician population represented in the sampling frame between the time when the sample was selected and the time the survey was conducted. The ratio adjustment is a multiplication factor which had as its numerator the number of physicians in the universe in each physician specialty group and region and as its denominator the estimated number of physicians in that particular specialty group and region. The numerator was based on figures obtained from the AMA and AOA master files for the survey year, and the denominator was the estimate of the numerator based on the sample.

4. Weight Smoothing

Each year there may be a few sample physicians whose final visit weights are large relative to those for the rest of the sample. There is a concern that those few may adversely affect the ability of the resulting statistics to reflect the universe, especially if the sampled patient visits to some of those few physicians should be unusual relative to the universe. Extremes in final weights also increase the resulting variances. Extreme weights can be truncated, but this leads to an understatement of the total visit count. The technique of weight smoothing is used instead, because it preserves the total estimated visit count within each specialty by shifting the "excess" from visits with the largest weights to visits with smaller weights.

Excessively large visit weights were trimmed, and a ratio adjustment was performed to yield the same estimated total visit count as the unsmoothed weights. The ratio adjustment is a multiplication factor that uses as its numerator the total visit count in each physician group before the largest weights are trimmed, and, as its denominator, the total visit count in the same group after the largest

weights are trimmed. This smoothing was done within each physician group defined by practice type and the nine Census divisions.

L. SAMPLING ERRORS

Procedures for calculating sampling errors as well as estimates of standard errors of statistics derived from NAMCS are described elsewhere in Appendix I of this document.

M. PATIENT VISIT WEIGHTS

The 2016 NAMCS data file contains patient visit weights (PATWT) for producing national and regional estimates from sample data. This is a vital component of the survey data and micro-data file users should understand how to use it correctly.

The statistics contained on the micro-data file reflect data concerning only a sample of patient visits, not a complete count of all the visits that occurred in the United States. Each record on the data file represents one visit in the abstracted sample of 13,165 visits. In order to obtain visit estimates from survey data, each record is assigned an inflation factor called the "patient visit weight." By aggregating the patient visit weights contained in the PATWT variable on the 13,165 sample records for 2016, the user can obtain the estimated total of 883,725,126 office visits made in the United States.

The marginal tables on pages 124-130 contain data on numbers of records for selected variables as well as the corresponding national estimated number of visits and drug mentions obtained by aggregating the PATWT version of "patient visit weights" on those records. Similar tables are also provided for physician-level estimates.

N. PHYSICIAN CODE and PATIENT CODE

The purpose of these codes is to allow for greater analytical depth by permitting the user to link all of the sampled records for an individual physician. This linkage enables users to conduct more comprehensive analysis without violating the confidentiality of patients or physicians.

To uniquely identify a record, both the 4-digit physician code and the 3-digit patient visit code must be used. Patient visit codes are merely a sequential numbering of the physician’s visits abstracted for NAMCS and alone will not uniquely identify visit records.

O. USE OF THE PHYSICIAN-LEVEL WEIGHT

The physician-level weight (PHYSWT) has been available on the public use file since the 2005 data release, but is available for earlier years in the NCHS Research Data Center. These weights allow data users to calculate physician-level estimates. There is one weight for each physician which appears on the first visit record only for that physician. When running an analysis of physician-level characteristics using PHYSWT, it is recommended to select only those records where PHYSWT is greater than 0. This will result in correct sample counts, which are useful for assessing reliability. Weighted estimates will be correct either way, because of the one weight per physician format.

It should be kept in mind, however, that estimates at the physician level generated using PHYSWT only reflect the characteristics of those physicians who saw patients in their sample week. There were an additional 185 physicians who responded to the 2016 NAMCS but did not see any patients during their sampled week due to being on vacation or other reasons. The physician estimates produced using NAMCS data in public use data files do not include data for such physicians nor physicians who did see

patients in their sample week but who did not have abstracted PRFs. Therefore, estimates made with PHYSWT may be biased due to the omission of such physicians, if such physicians have different characteristics than those who provided data on sample visits. Physician-level estimates from the NAMCS visit-level file are better for analyzing visit characteristics at the physician level, because such characteristics would not be biased by the omission of physicians who didn't see patients. For example, one could examine average time spent with physicians across physicians rather than simply across visits. This type of analysis is slightly complicated; a description along with sample SAS code is available at the Ambulatory Health Care Data website.

Data users should also keep in mind the effects of nonresponse bias when producing physician-level estimates. See page 3 for additional information. If there are questions, see page 2 for information on how to contact the Ambulatory and Hospital Care Statistics Branch.

REFERENCES

1. Hing E, Shimizu IM, Talwalkar A. Nonresponse bias in estimates from the 2012 National Ambulatory Medical Care Survey. National Center for Health Statistics. Vital Health Stat 2(171). 2016. http://www.cdc.gov/nchs/data/series/sr_02/sr02_171.pdf (accessed 12/28/18)

2. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services. Official version: International Classification of Diseases, Tenth Revision, Clinical Modification. FY 2016 release. https://www.cdc.gov/nchs/icd/icd10cm.htm (accessed 12/28/18)

3. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services. Official version: International Classification of Diseases, Ninth Revision, Clinical Modification, Sixth Edition. DHHS Pub No. (PHS) 11-1260.

4. U.S. Department of Health and Human Services. Centers for Medicare and Medicaid Services. ICD-10-CM and ICD-10 PCS and GEMs Archive. https://www.cms.gov/Medicare/Coding/ICD10/Archive-ICD-10-CM-ICD-10-PCS-GEMs.html (accessed 12/28/18)

5. Lau DT, Strashny A, Phan K, Blum A, Burke-Bebee S. Evaluation of transition from ICD–9–CM to ICD–10–CM diagnosis coding system in the National Ambulatory Medical Care Survey. National Health Statistics Reports; no 120. Hyattsville, MD: National Center for Health Statistics. 2018. https://www.cdc.gov/nchs/data/nhsr/nhsr120-508.pdf (accessed 12/28/18)

6. Parker JD, Talih M, Malec DJ, et al. National Center for Health Statistics Data Presentation Standards for Proportions. National Center for Health Statistics. Vital Health Stat 2(175). 2017. https://www.cdc.gov/nchs/data/series/sr_02/sr02_175.pdf (accessed 12/28/18)

7. Schneider D, Appleton L, McLemore T. A Reason for Visit Classification for Ambulatory Care. National Center for Health Statistics. Vital Health Stat 2(78). 1979.

8. National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey Reason for Visit Classification and Coding Manual: (updated annually). Ambulatory and Hospital Care Statistics Branch, Division of Health Care Statistics, National Center for Health Statistics.

9. National Ambulatory Medical Care Survey: Coding Requirements (updated annually). Ambulatory and Hospital Care Statistics Branch, Division of Health Care Statistics, National Center for Health Statistics.

10. Koch H, Campbell W. The Collection and Processing of Drug Information. National Ambulatory Medical Care Survey, 1980. National Center for Health Statistics. Vital Health Stat 2(90). 1982.

11. Food and Drug Administration. National Drug Code Directory, 1995 edition. Washington: Public Health Service. 1995.

II. CODEBOOK AND PHYSICIAN SPECIALTY LIST

A. CODEBOOK

Number of records = 13,165

This section consists of a detailed breakdown of each variable on the record, including a sequential item number, field length, file location, and brief description, along with valid codes. Most data are from the PRF, but there are also many items included from the Physician Induction Interview.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DATE OF VISIT
1	2	1-2	[VMONTH] MONTH OF VISIT 01-12: January-December
2	1	3	[VDAYR] DAY OF WEEK OF VISIT 1 = Sunday 2 = Monday 3 = Tuesday 4 = Wednesday 5 = Thursday 6 = Friday 7 = Saturday
3	3	4-6	[AGE] PATIENT AGE (reported in years or derived from date of visit and date of birth) Age has been top coded in accordance with NCHS confidentiality requirements. 000 = Under 1 year 001-091 = 1-91 years 092 = 92 years and over
4	1	7	[AGER] AGE RECODE 1 = Under 15 years 2 = 15-24 years 3 = 25-44 years 4 = 45-64 years 5 = 65-74 years 6 = 75 years and over

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
5	3	8-10	[AGEDAYS] AGE IN DAYS FOR PATIENTS LESS THAN ONE YEAR OF AGE (derived from date of visit and date of birth) -7 = Not applicable 0-364 (0 = Less than one day old)
6	1	11	[SEX] SEX 1 = Female 2 = Male
7	2	12-13	[PREGNANT] IS PATIENT PREGNANT? -9 = Blank -8 = Unknown -7 = Not Applicable 1 = Yes 2 = No
8	2	14-15	[GESTWK] IF PATIENT IS PREGNANT, SPECIFY GESTATION WEEK -9 = Blank -8 = Unknown -7 = Not Applicable 2-41
9	2	16-17	[ETHUN] UNIMPUTED ETHNICITY This variable is NOT imputed. Ethnicity data were missing for 25.6 percent of NAMCS visit records. -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Hispanic or Latino 2 = Not Hispanic or Latino
10	2	18-19	[RACEUN] UNIMPUTED RACE This variable is NOT imputed. Race data were missing for 27.7 percent of NAMCS visit records. -9 = Blank 1 = White 2 = Black or African American 3 = Asian 4 = Native Hawaiian or Other Pacific Islander 5 = American Indian or Alaska Native 6 = More than one race reported

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
11	1	20	[ETHIM] IMPUTED ETHNICITY Missing data for ethnicity were imputed for this variable. Ethnicity data were missing for 25.6 percent of NAMCS visit records. 1 = Hispanic 2 = Not Hispanic
12	1	21	[RACER] IMPUTED RACE Missing data for race were imputed for this variable. Race data were missing for 27.7 percent of NAMCS visit records. 1 = White 2 = Black 3 = Other
13	1	22	[RACERETH] IMPUTED RACE/ETHNICITY Missing race and ethnicity data were imputed for this variable. Both race and ethnicity were missing for 19.6 percent of records. Race alone was missing for an additional 8.1 percent and ethnicity alone was missing for an additional 6.0 percent of records. NOTE: In survey years prior to 2009, the categories were Non-Hispanic White, Non-Hispanic Black, Hispanic, Asian, Native Hawaiian/Other Pacific Islander, American Indian or Alaska Native, and Multiple Races. Starting in 2009, the decision was made to reformulate this item. Hispanic can now be of any race. 1 = White Only, Non-Hispanic 2 = Black Only, Non-Hispanic 3 = Hispanic 4 = Other Race/Multiple Race, Non-Hispanic
14	1	23	[NOPAY] NO RESPONSE TO EXPECTED SOURCE(S) OF PAYMENT FOR THIS VISIT 0 = At least one source of payment was reported 1 = All expected source of payment boxes are blank
15	1	24	[PAYPRIV] EXPECTED SOURCE OF PAYMENT: PRIVATE INSURANCE 0 = No 1 = Yes
16	1	25	[PAYMCARE] EXPECTED SOURCE OF PAYMENT: MEDICARE 0 = No 1 = Yes

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
17	1	26	[PAYMCAID] EXPECTED SOURCE OF PAYMENT: MEDICAID OR CHIP OR OTHER STATE-BASED PROGRAM 0 = No 1 = Yes
18	1	27	[PAYWKCMP] EXPECTED SOURCE OF PAYMENT: WORKER'S COMPENSATION 0 = No 1 = Yes
19	1	28	[PAYSELF] EXPECTED SOURCE OF PAYMENT: SELF-PAY 0 = No 1 = Yes
20	1	29	[PAYNOCHG] EXPECTED SOURCE OF PAYMENT: NO CHARGE/CHARITY 0 = No 1 = Yes
21	1	30	[PAYOTH] EXPECTED SOURCE OF PAYMENT: OTHER 0 = No 1 = Yes
22	1	31	[PAYDK] EXPECTED SOURCE OF PAYMENT: UNKNOWN 0 = No 1 = Yes

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
23	2	32-33	[PAYTYPER] RECODED PRIMARY EXPECTED SOURCE OF PAYMENT FOR THIS VISIT (Recoded from 'Expected Sources of Payment for this Visit' using this hierarchy of payment categories: Medicare, Medicaid or CHIP or other state-based program, Private Insurance, Worker's Compensation, Self-Pay, No Charge/Charity, Other, Unknown)

IMPORTANT: For more information about earlier versions of the variable PAYTYPE, and variable PAYTYPER which used a different hierarchy of payment categories, please see the 2009 NAMCS Public Use Data File Documentation.

-9 = Blank
-8 = Unknown
1 = Private insurance
2 = Medicare
3 = Medicaid or CHIP or other state-based program
4 = Worker's Compensation
5 = Self-pay
6 = No charge/charity
7 = Other

24	2	34-35	[USETOBAC] TOBACCO USE

-9 = Blank
-8 = Unknown
1 = Not current
2 = Current

25	2	36-37	[EVERTOBAC] PRIOR TOBACCO USE

-8 = Unknown
1 = Never
2 = Former

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
26	2	38-39	[INJURY] IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE/POISONING, OR ADVERSE EFFECT OF MEDICAL/SURGICAL TREATMENT?

This is a summary variable provided for trending with previous years of data, although the format has changed slightly from previous years to better reflect uncertainties and nuances in the injury data. It has been recoded from the INJPOISAD variable below.

This item reflects a broad definition of injury traditionally used in NAMCS, but some changes have been made in 2016. It includes visits with any of the following: NCHS Reason for Visit Classification codes in the injury, poisoning, or adverse effects module (50000-59999), diagnosis codes in the 'S' or 'T' chapters of ICD-10-CM, diagnosis codes for complications of medical or surgical care (located throughout the ICD-10-CM; a list of codes is available by contacting AHCSB); and cause of injury codes in the 'V', 'W', 'X' and 'Y' chapters of ICD-10-CM. This definition of injury is used in the INJURY, INJPOISAD, and INTENT15 variables. It is somewhat narrower than the broad definition used in NAMCS data in the past. The older definition included other conditions, such as carpal tunnel syndrome, which were outside of the Injury and Poisoning chapter of ICD-9-CM.

-9 = Blank
-8 = Unknown
0 = No
1 = Yes
2 = Questionable injury status (visit was reported as injury related but lacked any of the reason, diagnosis, and cause codes used to define an injury visit)

27	2	40-41	[INJPOISAD] IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE/POISONING OR ADVERSE EFFECT OF MEDICAL/ SURGICAL TREATMENT?

This variable reflects the injury item format used since 2012. INJPOISAD was created directly from reason for visit, diagnosis, and cause of injury codes first, followed by consideration of unedited data which indicated an injury but where no concrete evidence of injury existed.

-9 = Blank
-8 = Unknown
1 = Yes, injury/trauma
2 = Yes, overdose/poisoning
3 = Yes, adverse effect of medical/surgical treatment
4 = No, visit is not related to injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment
5 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
28	2	42-43	[INJURY72] Did the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment occur within 72 hours prior to the date and time of this visit? [Note that in 2015, the wording changed to include adverse effects.] -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
29	2	44-45	[INTENT] IS THIS INJURY/TRAUMA OR OVERDOSE/POISONING INTENTIONAL OR UNINTENTIONAL? NOTE: The categories for this item have been the same since 2014. In 2014, the order of the categories was changed on the survey instrument. Previously, “Unintentional” was listed first. Use caution when combining data across years. -9 = Blank -8 = Unknown/intent unclear 1 = Intentional 2 = Unintentional 3 = Intent unclear (note that this category from the survey instrument was simply a renaming/replacement of the “Unknown” category used for this item on the instrument prior to 2012. Responses have been recoded to -8, our standard coding convention for cases where the answer to the item is unknown) 4 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)
30	2	46-47	[INJURY_ENC] Type of encounter for injury visits This variable was added to give additional detail from the 7th digit of the original ICD-10-CM code. Since the ICD-10-CM codes have been truncated on the public use file, information contained in the 7th digit would otherwise not be available on the public use file. -9 = Not applicable/Blank 1 = Initial encounter 2 = Subsequent encounter 3 = Sequela encounter 4 = Both initial and subsequent encounter codes present 5 = Both Initial and sequela encounter codes present 6 = Both subsequent and sequela encounter codes present 7 = Initial, subsequent, and sequela encounter codes present

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			PATIENT'S REASON(S) FOR VISIT (See page 29 in Section I and Coding List in Appendix II.)
31	5	48-52	[RFV1] REASON # 1 -9 = Blank 10050-89990 = 1005.0-8999.0
32	5	53-57	[RFV2] REASON # 2 -9 = Blank 10050-89990 = 1005.0-8999.0 10050-89990 = 1005.0-8999.0
33	5	58-62	[RFV3] REASON # 3 -9 = Blank 10050-89990 = 1005.0-8999.0
34	5	63-67	[RFV4] REASON # 4 -9 = Blank 10050-89990 = 1005.0-8999.0
35	5	68-72	[RFV5] REASON # 5 -9 = Blank 10050-89990 = 1005.0-8999.0
			CAUSE OF INJURY/TRAUMA, OVERDOSE/POISONING OR ADVERSE EFFECT OF MEDICAL/SURGICAL TREATMENT (See page 30 in Section I for explanation of codes.)
36	4	73-76	[CAUSE1] CAUSE #1 (ICD-10-CM, V-Y Codes) External cause of injury codes are from the V, W, X, and Y chapters of ICD-10-CM. Only the first 4 digits of each code are provided. There is an implied decimal between the third and fourth digits. -9 = Not applicable/Blank V000-Y000 = V00.0 – Y99.9
37	4	77-80	[CAUSE2] CAUSE #2 (ICD-10-CM, V-Y codes) See CAUSE1.
38	4	81-84	[CAUSE3] CAUSE #3 (ICD-10-CM, V-Y codes) See CAUSE1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
39	2	85-86	[PRIMCARE] ARE YOU THE PATIENT'S PRIMARY CARE PHYSICIAN? -9 = Blank -8 = Unknown 1 = Yes 2 = No
40	2	87-88	[REFER] WAS PATIENT REFERRED FOR THIS VISIT? -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
41	1	89	[SENBEFOR] HAS THE PATIENT BEEN SEEN IN YOUR PRACTICE BEFORE? 1 = Yes, established patient 2 = No, new patient
42	3	90-92	[PASTVIS] HOW MANY PAST VISITS IN THE LAST 12 MONTHS? The value has been topcoded at 35 for visits to all specialties except psychiatry and at 135 for visits to psychiatrists. Top coding of outlier values was done in accordance with NCHS confidentiality requirements. -7 = Not applicable 0-34 = 0-34 visits 35 = 35 visits or more (applies to all specialties except psychiatry) 36-131 (psychiatry only)
43	2	93-94	[MAJOR] MAJOR REASON FOR THIS VISIT -9 = Blank 1 = New problem (<3 mos. onset) 2 = Chronic problem, routine 3 = Chronic problem, flare-up 4 = Pre surgery 5 = Post surgery 6 = Preventive care (e.g. routine prenatal, well-baby, screening, insurance, general exams)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DIAGNOSIS (See page 30, Section 1 for explanation of coding.) Note: Diagnosis was modified on 1.3 percent of records due to confidentiality requirements.
44	4	95-98	[DIAG1] DIAGNOSIS #1 (ICD-10-CM) There is an implied decimal between the third and fourth digits; for inapplicable or masked fourth digits, a dash is inserted. -9 = Blank (no entry made) A000 – Z998 = A00.0-Z99.8 ZZZ0 = Non-codable, insufficient information for coding, illegible ZZZ1 = Left before being seen; patient walked out; “eloped”, left against medical advice (AMA) ZZZ2 = Transferred to another facility; sent to see specialist (discharge order rather than diagnosis) ZZZ3 = Insurance/HMO will not authorize treatment ZZZ4 = Entry of "none," "no diagnosis," "no disease," or "healthy" (this is the only entry) ZZZ5 = Entry of "Not applicable”, “Not Available”, “NA” or “Blank”
45	2	99-100	[PRDIAG1] IS DIAGNOSIS #1 PROBABLE, QUESTIONABLE, OR RULE OUT? -7 = Not applicable 1 = Yes 2 = No
46	4	101-104	[DIAG2] DIAGNOSIS #2 (ICD-10-CM) There is an implied decimal between the third and fourth digits; for inapplicable or masked fourth digits, a dash is inserted. See DIAGNOSIS #1 for details.
47	2	105-106	[PRDIAG2] IS DIAGNOSIS #2 PROBABLE, QUESTIONABLE, OR RULE OUT? -7 = Not applicable 1 = Yes 2 = No
48	4	107-110	[DIAG3] DIAGNOSIS #3 (ICD-10-CM) There is an implied decimal between the third and fourth digits; for inapplicable or masked fourth digits, a dash is inserted. See DIAGNOSIS #1 for details.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
49	2	111-112	[PRDIAG3] IS DIAGNOSIS #3 PROBABLE, QUESTIONABLE, OR RULE OUT? -7 = Not applicable 1 = Yes 2 = No
50	4	113-116	[DIAG4] DIAGNOSIS #4 (ICD-10-CM) There is an implied decimal between the third and fourth digits; for inapplicable or masked fourth digits, a dash is inserted. See DIAGNOSIS #1 for details.
51	2	117-118	[PRDIAG4] IS DIAGNOSIS #4 PROBABLE, QUESTIONABLE, OR RULE OUT? -7 = Not applicable 1 = Yes 2 = No
52	4	119-122	[DIAG5] DIAGNOSIS #5 (ICD-10-CM) There is an implied decimal between the third and fourth digits; for inapplicable or masked fourth digits, a dash is inserted. See DIAGNOSIS #1 for details.
53	2	123-124	[PRDIAG5] IS DIAGNOSIS #3 PROBABLE, QUESTIONABLE, OR RULE OUT? -7 = Not applicable 1 = Yes 2 = No REGARDLESS OF THE DIAGNOSES WRITTEN ABOVE, DOES THE PATIENT NOW HAVE: 0 = No 1 = Yes
54	1	125	[ETOHAB] Alcohol misuse, abuse, or dependence
55	1	126	[ALZHD] Alzheimer’s Disease/Dementia
56	1	127	[ARTHRTIS] Arthritis
57	1	128	[ASTHMA] Asthma
58	2	129-130	[ASTH_SEV] Asthma severity -9 = Blank -7 = Not applicable 1 = Intermittent 2 = Mild persistent 3 = Moderate persistent 4 = Severe persistent 5 = Other, specify 6 = None recorded

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
59	2	131-132	[ASTH_CON] Asthma control -9=Blank -7=Not applicable 1=Well-controlled 2=Not well controlled 3=Very poorly controlled 4=Other, specify 5=None recorded
60	1	133	[ADD] Attention deficit disorder (ADD)/ Attention deficit hyperactivity disorder (ADHD)
61	1	134	[AUTISM] Autism spectrum disorder
62	1	135	[CANCER] Cancer
63	1	136	[CEBVD] Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)
64	1	137	[CKD] Chronic kidney disease (CKD)
65	1	138	[COPD] Chronic obstructive pulmonary disease (COPD)
66	1	139	[CHF] Congestive heart failure (CHF)
67	1	140	[CAD] Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)
68	1	141	[DEPRN] Depression6
69	1	142	[DIABTYP1] Diabetes mellitus (DM), type I
70	1	143	[DIABTYP2] Diabetes mellitus (DM), type II
71	1	144	[DIABTYP0] Diabetes mellitus (DM), type unspecified
72	1	145	[ESRD] End stage renal disease (ESRD)
73	1	146	[HEPB] Hepatitis B
74	1	147	[HEPC] Hepatitis C
75	1	148	[HPE] History of pulmonary embolism (PE), or deep vein thrombosis (DVT), or venous thromboembolism (VTE)
76	1	149	[HIV] HIV infection/AIDS
77	1	150	[HYPLIPID] Hyperlipidemia
78	1	151	[HTN] Hypertension
79	1	152	[OBESITY] Obesity
80	1	153	[OSA] Obstructive sleep apnea (OSA)
81	1	154	[OSTPRSIS] Osteoporosis
82	1	155	[SUBSTAB] Substance abuse or dependence
83	1	156	[NOCHRON] None of the above 0 = “None” not checked 1 = “None” checked 2 = Entire item blank
84	2	157-158	[TOTCHRON] TOTAL NUMBER OF CHRONIC CONDITIONS -9 = Entire item blank 0-10 (reported range)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			VITAL SIGNS
85	1	159	[HTTAKE] Was height measurement reported? (Created during data processing based on reported data.) 0 = No 1= Yes
86	2	160-161	[HTIN] PATIENT'S HEIGHT (inches) Height has been top coded in accordance with NCHS confidentiality requirements. -9 = Blank 12 - 71 inches (reported range) 72 = 72 inches or more (top code for females) 77 = 77 inches or more (top code for males)
87	1	162	[WTTAKE] Was weight measurement reported? (Created during data processing based on reported data.) 0 = No 1= Yes
88	3	163-165	[WTLB] PATIENT'S WEIGHT (pounds) Weight has been top coded in accordance with NCHS confidentiality requirements. -9 = Blank 5-349 (reported range) 350 = 350 lbs. or more
89	8	166-173	[BMI] Body-Mass Index This was calculated from Patient's Height and Weight during data processing. It contains a decimal point and up to 2 decimal places. BMI was not calculated for pregnant females, patients under age 2, or patients with a recorded height and/or weight that fell outside of acceptable ranges. Also, BMI was recalculated to reflect topcoded values for height and weight. -9 = Missing data -7 = Not calculated -5 = Height and/or weight outside of acceptable ranges 11.90 – 64.01 (reported range)
90	1	174	[TEMPTAKE] Was temperature reported? (Created during data processing based on reported data.) 0 = No 1= Yes

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
91	4	175-178	[TEMPF] Temperature (Fahrenheit) There is an implied decimal between the third and fourth digits. -9 = Blank 927 - 1040 = 92.7 - 104.0 Fahrenheit (reported range)
92	1	179	[BLODPRES] Was blood pressure reported? (Created during data processing based on reported data.) 0 = No 1= Yes
93	3	180-182	[BPSYS] Blood pressure – systolic -9 = Blank 66-249 (reported range)
94	3	183-185	[BPDIAS] Blood pressure – diastolic -9 = Blank 22-146 (reported range) 998 = P, Palp, DOP, or DOPPLER
			SERVICES
95	1	186	[SERVICES] Were any examinations/screenings, laboratory tests, imaging, procedures, treatments, health education/counseling, or other services ordered or provided at this visit? NOTE: Prior to 2012, diagnostic and screening services were collected in one question on the PRF, non-medication services in another, and health education in a third. As described in the annual public use file documentation, from 2009-2011, the diagnostic and screening services item was combined with the non-medication services item to create a combined services item during data processing. Starting in 2012, all services were combined into one item on the PRF. 0 = No services were reported 1 = At least one service was reported
			0 = No, 1 = Yes for each category below
			Examinations:
96	1	187	[ETOH] Alcohol abuse screening (includes AUDIT, MAST, CAGE, T-ACE)
97	1	188	[BREAST] Breast exam
98	1	189	[DEPRESS] Depression screening
99	1	190	[DVS] Domestic violence screening
100	1	191	[FOOT] Foot exam
101	1	192	[NEURO] Neurologic exam

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
102	1	193	[PELVIC] Pelvic exam
103	1	194	[RECTAL] Rectal exam
104	1	195	[RETINAL] Retinal/Eye exam
105	1	196	[SKIN] Skin exam
106	1	197	[SUBST] Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10]
			Laboratory tests:
107	1	198	[BMP] Basic metabolic panel ((BMP)
108	1	199	[CBC] CBC (Complete blood count)
109	1	200	[CHLAMYD] Chlamydia test
110	1	201	[CMP] Comprehensive metabolic panel (CMP)
111	1	202	[CREAT] Creatinine/Renal function panel
112	1	203	[BLDCX] Culture, blood
113	1	204	[TRTCX] Culture, throat
114	1	205	[URNCX] Culture, urine
115	1	206	[OTHCX] Culture, other
116	1	207	[GLUCOSE] Glucose, serum
117	1	208	[GCT] Gonorrhea test
118	1	209	[HGBA] HgbA1C (Glycohemoglobin)
119	1	210	[HEPTEST] Hepatitis testing/Hepatitis panel
120	1	211	[HIVTEST] HIV test
121	1	212	[HPVDNA] HPV DNA test
122	1	213	[CHOLEST] Lipid profile
123	1	214	[HEPATIC] Liver enzyme/hepatic function panel
124	1	215	[PAP] Pap test
125	1	216	[PREGTEST] Pregnancy/HCG test
126	1	217	[PSA] PSA (Prostate specific antigen)
127	1	218	[STREP] Rapid strep test
128	1	219	[THYROID] TSH/Thyroid panel
129	1	220	[URINE] Urinalysis (UA)
130	1	221	[VITD] Vitamin D test
			Imaging:
131	1	222	[ANYIMAGE] This item was created during data processing and indicates whether any of the imaging boxes were checked.
132	1	223	[BONEDENS] Bone mineral density
133	1	224	[CATSCAN] CT Scan
134	1	225	[ECHOCARD] Echocardiogram
135	1	226	[OTHULTRA] Other ultrasound
136	1	227	[MAMMO] Mammography
137	1	228	[MRI] MRI
138	1	229	[XRAY] X-ray and procedures
139	1	230	[OTHIMAGE] Other imaging NOTE: This was not a checkbox category on the survey. It was created during data processing based on responses to the “other services not listed” items, in which data respondents could enter

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			names of procedures which were later coded using ICD-10-CM procedure codes.
.			Procedures:
140	1	231	[AUDIO] Audiometry
141	1	232	[BIOPSY] Biopsy
142	2	233-234	[BIOPROV] Biopsy provided -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
143	1	235	[CARDIAC] Cardiac stress test
144	1	236	[COLON] Colonoscopy
145	1	237	[CRYO] Cryosurgery (cryotherapy)/Destruction of tissue
146	1	238	[EKG] EKG/ECG
147	1	239	[EEG] Electroencephalogram (EEG)
148	1	240	[EMG] Electromyogram (EMG)
149	1	241	[EXCISION] Excision of tissue
150	2	242-243	[EXCIPROV] Excision of tissue provided -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
151	1	244	[FETAL] Fetal monitoring
152	1	245	[PEAK] Peak flow
153	1	246	[SIGMOID] Sigmoidoscopy
154	2	247-248	[SIGPROV] Sigmoidoscopy provided -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
155	1	249	[SPIRO] Spirometry
156	1	250	[TONO] Tonometry
157	1	251	[TBTEST] Tuberculosis skin testing/PPD
158	1	252	[EGD] Upper gastrointestinal endoscopy/EGD
159	1	253	[SIGCOLON] Sigmoidoscopy/Colonoscopy This item was created during data processing and indicates whether any type of sigmoidoscopy or colonoscopy was ordered or provided, as reported in the checkbox data or write-in procedures.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			Treatments:
160	1	254	[CSW] Cast/Splint/Wrap
161	1	255	[CAM] Complementary and alternative medicine (CAM)
162	1	256	[DME] Durable medical equipment
163	1	257	[HOMEHLTH] Home health care
164	1	258	[MENTAL] Mental health counseling, excluding psychotherapy
165	1	259	[OCCUPY] Occupational therapy
166	1	260	[PT] Physical therapy
167	1	261	[PSYCHOTH] Psychotherapy
168	1	262	[RADTHER] Radiation therapy
169	1	263	[WOUND] Wound care
			Health education/Counseling:
170	1	264	[ETOHED] Alcohol abuse counseling
171	1	265	[ASTHMAED] Asthma education
172	1	266	[ASTHMAP] Asthma action plan given to patient
173	1	267	[DIAEDUC] Diabetes education
174	1	268	[DIETNUTR] Diet/Nutrition
175	1	269	[EXERCISE] Exercise
176	1	270	[FAMPLAN] Family planning/Contraception
177	1	271	[GENETIC] Genetic counseling
178	1	272	[GRWTHDEV] Growth/Development
179	1	273	[INJPREV] Injury prevention
180	1	274	[STDPREV] STD prevention
181	1	275	[STRESMGT] Stress management
182	1	276	[SUBSTED] Substance abuse counseling
183	1	277	[TOBACED] Tobacco use/Exposure
184	1	278	[WTREDUC] Weight reduction
185	1	279	[OTHSERV] Other services not listed
			PROCEDURES

Procedures 1-9 are derived from the write-in fields under “Other Services Not Listed” on the PRF. To get a complete picture of the number and type of procedures reported at a visit, data users should include results from all of the procedure fields.

186	7	280-286	[PROC1] Write-in procedure #1 Based on ICD-10-CM/PCS, this is a left-justified alphanumeric code. Each of the 7 characters represents a different dimension as described in more detail on pages 3-4 and in the Medical Coding section on page 31. If a dimension could not be coded, an underscore was inserted. -9 = Blank 005_3ZZ - HZ63ZZZ 9999999 = Illegible/unable to code

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
187	7	287-293	[PROC2] Write-in procedure #2: see PROC1 for details
188	7	294-300	[PROC3] Write-in procedure #3: see PROC1 for details
189	7	301-307	[PROC4] Write-in procedure #4: see PROC1 for details
190	7	308-314	[PROC5] Write-in procedure #5: see PROC1 for details
191	7	315-321	[PROC6] Write-in procedure #6: see PROC1 for details
192	7	322-328	[PROC7] Write-in procedure #7: see PROC1 for details
193	7	329-335	[PROC8] Write-in procedure #8: see PROC1 for details
194	7	336-342	[PROC9] Write-in procedure #9: see PROC1 for details
195	2	343-344	[SERVCNT] Total number of services reported as ordered or provided at the visit. Includes all services and vital sign determinations, including write-in entries for procedures (adjusted to avoid double counting between procedures that could be reported as both a checkbox and with more detail in the write-in field). 0-28 (reported range)
196	1	345	[ALLSERV] Were any services ordered or provided at the visit, including vital sign determinations? 0 = No services were ordered or provided at the visit 1 = At least one service was ordered or provided at the visit MEDICATIONS & IMMUNIZATIONS (See page 32 for more information. See Appendix III for Code List.)
197	1	346	[MED] WERE ANY PRESCRIPTION OR NON-PRESCRIPTION DRUGS ORDERED OR PROVIDED (BY ANY ROUTE OF ADMINISTRATION) AT THIS VISIT? 0 = No 1 = Yes 2 = Entire item blank, including “None” box
198	5	347-351	[MED1] MEDICATION #1 -9 = Blank 00000-99227 = 00000-99227 99980 = Unknown Entry; Other 99999 = Illegible Entry
199	5	352-416	[MED2] MEDICATION #2 - See MED1
200	5	357-361	[MED3] MEDICATION #3 - See MED1
201	5	362-366	[MED4] MEDICATION #4 - See MED1
202	5	367-371	[MED5] MEDICATION #5 - See MED1
203	5	372-376	[MED6] MEDICATION #6 - See MED1
204	5	377-381	[MED7] MEDICATION #7 - See MED1
205	5	382-396	[MED8] MEDICATION #8 - See MED1
206	5	387-391	[MED9] MEDICATION #9 - See MED1
207	5	392-396	[MED10] MEDICATION #10 - See MED1
208	5	397-401	[MED11] MEDICATION #11 - See MED1
209	5	402-406	[MED12] MEDICATION #12 - See MED1
210	5	407-411	[MED13] MEDICATION #13 - See MED1
211	5	412-416	[MED14] MEDICATION #14 - See MED1
212	5	417-421	[MED15] MEDICATION #15 - See MED1
213	5	422-426	[MED16] MEDICATION #16 - See MED1

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
214	5	427-431	[MED17] MEDICATION #17 - See MED1
215	5	432-436	[MED18] MEDICATION #18 - See MED1
216	5	437-441	[MED19] MEDICATION #19 - See MED1
217	5	442-446	[MED20] MEDICATION #20 - See MED1
218	5	447-451	[MED21] MEDICATION #21 - See MED1
219	5	452-456	[MED22] MEDICATION #22 - See MED1
220	5	457-461	[MED23] MEDICATION #23 - See MED1
221	5	462-466	[MED24] MEDICATION #24 - See MED1
222	5	467-471	[MED25] MEDICATION #25 - See MED1
223	5	472-476	[MED26] MEDICATION #26 - See MED1
224	5	477-481	[MED27] MEDICATION #27 - See MED1
225	5	482-486	[MED28] MEDICATION #28 - See MED1
226	5	487-491	[MED29] MEDICATION #29 - See MED1
227	5	492-496	[MED30] MEDICATION #30 - See MED1
228	2	497-498	[NCMED1] Was medication #1 new or continued? -9 = Blank -7 = Not applicable (no drug listed) 1 = New 2 = Continued
229	2	499-500	[NCMED2] Was medication #2 new or continued? See NCMED1.
230	2	501-502	[NCMED3] Was medication #3 new or continued? See NCMED1.
231	2	503-504	[NCMED4] Was medication #4 new or continued? See NCMED1.
232	2	505-506	[NCMED5] Was medication #5 new or continued? See NCMED1.
233	2	507-508	[NCMED6] Was medication #6 new or continued? See NCMED1.
234	2	509-510	[NCMED7] Was medication #7 new or continued? See NCMED1.
235	2	511-512	[NCMED8] Was medication #8 new or continued? See NCMED1.
236	2	513-514	[NCMED9] Was medication #9 new or continued? See NCMED1.
237	2	515-516	[NCMED10] Was medication #10 new or continued? See NCMED1.
238	2	517-518	[NCMED11] Was medication #11 new or continued? See NCMED1.
239	2	519-520	[NCMED12] Was medication #12 new or continued? See NCMED1.
240	2	521-522	[NCMED13] Was medication #13 new or continued? See NCMED1.
241	2	523-524	[NCMED14] Was medication #14 new or continued? See NCMED1.
242	2	525-526	[NCMED15] Was medication #15 new or continued? See NCMED1.
243	2	527-528	[NCMED16] Was medication #16 new or continued? See NCMED1.
244	2	529-530	[NCMED17] Was medication #17 new or continued? See NCMED1.
245	2	531-532	[NCMED18] Was medication #18 new or continued? See NCMED1.
246	2	533-534	[NCMED19] Was medication #19 new or continued? See NCMED1.
247	2	535-536	[NCMED20] Was medication #20 new or continued? See NCMED1.
248	2	537-538	[NCMED21] Was medication #21 new or continued? See NCMED1.
249	2	539-540	[NCMED22] Was medication #22 new or continued? See NCMED1.
250	2	541-542	[NCMED23] Was medication #23 new or continued? See NCMED1.
251	2	543-544	[NCMED24] Was medication #24 new or continued? See NCMED1.
252	2	545-546	[NCMED25] Was medication #25 new or continued? See NCMED1.
253	2	547-548	[NCMED26] Was medication #26 new or continued? See NCMED1.
254	2	549-550	[NCMED27] Was medication #27 new or continued? See NCMED1.
255	2	551-552	[NCMED28] Was medication #28 new or continued? See NCMED1.
256	2	553-554	[NCMED29] Was medication #29 new or continued? See NCMED1.
257	2	555-556	[NCMED30] Was medication #30 new or continued? See NCMED1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
258	2	557-558	[NUMMED] NUMBER OF MEDICATIONS CODED 0 – 30
259	2	559-560	[NUMNEW] NUMBER OF NEW MEDICATIONS CODED 0 – 30
260	2	561-562	[NUMCONT] NUMBER OF CONTINUED MEDICATIONS CODED 0 – 30
			NOTE: For NUMNEW and NUMCONT, the value '0' can reflect the following situations: for NUMNEW, a) no drug listed; b) drug listed as continued medication only; or c) drug listed but unknown whether new or continued; for NUMCONT, a) no drug listed; b) drug listed as new medication only, or c) drug listed but unknown whether new or continued
			PROVIDERS SEEN
			0 = No, 1 = Yes
261	1	563	[NOPROVID] No answer to item
262	1	564	[PHYS] Physician
263	1	565	[PHYSASST] Physician assistant
264	1	566	[NPNMW] Nurse practitioner/Midwife
265	1	567	[RNLPN] RN/LPN
266	1	568	[MHP] Mental health provider
267	1	569	[OTHPROV] Other provider
268	1	570	[PROVNONE] None; no providers seen
269	3	571-573	[TIMEMD] TIME SPENT WITH MD (in minutes) Time spent with MD has been top coded in accordance with NCHS confidentiality requirements.
			0-89 minutes 90 = 90 minutes or more
			VISIT DISPOSITION
			0 = No, 1 = Yes
270	1	574	[NODISP] No answer to item
271	1	575	[RETREFPHY] Return to referring physician
272	1	576	[REFOTHMD] Refer to other physician
273	1	577	[RETAPPT1] Return in less than 1 week
274	1	578	[RETAPPT2] Return in 1 week to less than 2 months
275	1	579	[RETAPPT3] Return in 2 months or greater
276	1	580	[RETUNSP] Return at unspecified time
277	1	581	[RETNEED] Return as needed (p.r.n.)
278	1	582	[ERADMHOS] Refer to emergency department/Admit to hospital
279	1	583	[OTHDISP] Other visit disposition

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			TESTS
			NOTE: These data were only collected for visits to selected specialties. Specialties not included were the following: general surgery, orthopedic surgery, dermatology, urology, neurology, psychiatry, ophthalmology, and otolaryngology.
280	2	584-585	[CHOL] WAS BLOOD FOR TOTAL CHOLESTEROL TEST DRAWN ON THE DAY OF THE SAMPLED VISIT OR DURING THE 12 MONTHS PRIOR TO THE VISIT? -9 = Blank -7 = Not applicable, provider not sampled 1 = Yes 2 = None found within 12 months
281	3	586-588	[CHOLRES] MOST RECENT RESULT FOR TOTAL CHOLESTEROL -9 = Blank -8 = Unknown -7 = Not applicable, provider not sampled 0-376 mg/dL (reported range)
282	4	589-592	[DAYDCHOL] DIFFERENCE IN DAYS BETWEEN VISIT DATE AND DATE OF CHOLESTEROL LAB RESULT -900 = Blank -800 = Unknown -700 = Not applicable, provider not sampled -365 to 0 = Up to 365 days before date of visit to date of visit
283	2	593-594	[HDL] WAS BLOOD FOR HIGH DENSITY LIPOPROTEIN (HDL) TEST DRAWN ON THE DAY OF THE SAMPLED VIIST OR DURING THE 12 MONTHS PRIOR TO THE VISIT? -9 = Blank -7 = Not applicable, provider not sampled 1 = Yes 2 = None found within 12 months
284	3	595-597	[HDLRES] MOST RECENT RESULT FOR HIGH DENSITY LIPOPROTEIN -9 = Blank -8 = Unknown -7 = Not applicable, provider not sampled 14-320 mg/dL
285	4	598-601	[DAYDHDL] DIFFERENCE IN DAYS BETWEEN VISIT DATE AND DATE OF HDL LAB RESULT -900 = Blank -800 = Unknown -700 = Not applicable, provider not sampled -365 to 0 = Up to 365 days before date of visit to date of visit

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
286	2	602-603	[LDL] WAS BLOOD FOR LOW DENSITY LIPOPROTEIN (LDL) TEST DRAWN ON THE DAY OF THE SAMPLED VISIT OR DURING THE 12 MONTHS PRIOR TO THE VISIT? -9 = Blank -7 = Not applicable, provider not sampled 1 = Yes 2 = None found within 12 months
287	3	604-606	[LDLRES] MOST RECENT RESULT FOR LOW DENSITY LIPOPROTEIN (LDL) -9 = Blank -8 = Unknown -7 = Not applicable, provider not sampled 13-278 mg/dL
288	4	607-610	[DAYDLDL] DIFFERENCE IN DAYS BETWEEN VISIT DATE AND DATE OF LOW DENSITY LIPOPROTEIN (LDL) LAB RESULT -900 = Blank -800 = Unknown -700 = Not applicable, provider not sampled -365 to 0 = Up to 365 days before date of visit to date of visit
289	4	611-614	[LIPIDERR] CALCULATED LDL RESULT. NOT TO BE USED FOR ANALYSIS. This variable is to be used for comparison with the LDLRES value to point out possible errors in the lipid test reporting. -999 = Blank -2 - 261

Note: LIPIDERR was calculated for records with non-negative values for ALL lipid numbers (cholesterol, HDL, LDL, and TGS) and only when the date of the test matched for all four variables. The following formula was used: LIPIDERR=(CHOLRES-HDLRES-(TGSRES/5)). The value was then rounded. Some lab values were capped during data collection, which should be considered when interpreting LIPIDERR.

290	4	615-618	[LDLDIFF] DIFFERENCE BETWEEN REPORTED LDL RESULT (LDLRES) AND CALCULATED LDL (LIPIDERR). NOT TO BE USED FOR ANALYSIS. This variable is to be used for comparison to the LDLRES value in order to point out possible errors that may exist in the lipid test reporting. -999 = Blank -101 – 159
291	2	619-620	[TGS] WAS BLOOD FOR TRIGLYCERIDES TEST DRAWN ON THE DAY OF THE SAMPLED VISIT OR DURING THE 12 MONTHS PRIOR TO THE VISIT? -9 = Blank -7 = Not applicable, provider not sampled 1 = Yes 2 = None found within 12 months

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
292	3	621-623	[TGSRES] MOST RECENT RESULT FOR TRIGLYCERIDES -9 = Blank -8 = Unknown -7 = Not applicable, provider not sampled 33-845 mg/dL
293	4	624-627	[DAYDTGS] DIFFERENCE IN DAYS BETWEEN VISIT DATE AND DATE OF TRIGLYCERIDES LAB RESULT -900 = Blank -800 = Unknown -700 = Not applicable, provider not sampled -365 to 0 = Up to 365 days before date of visit to date of visit
294	2	628-629	[A1C] WAS BLOOD FOR GLYCOHEMOGLOBIN (HbA1c) TEST DRAWN ON THE DAY OF THE SAMPLED VISIT OR DURING THE 12 MONTHS PRIOR TO THE VISIT? -9 = Blank -7 = Not applicable, provider not sampled 1 = Yes 2 = None found within 12 months
295	4	630-633	[A1CRES] MOST RECENT RESULT FOR GLYCOHEMOGLOBIN (HbA1c)TRIGLYCERIDES TEST -9 = Blank -8 = Unknown -7 = Not applicable, provider not sampled 1.0 - 17.2%
296	4	634-637	[DAYDA1C] DIFFERENCE IN DAYS BETWEEN VISIT DATE AND DATE OF GLYCOHEMOGLOBIN (HbA1c) LAB RESULT -900 = Blank -800 = Unknown -700 = Not applicable, provider not sampled -365 to 0 = Up to 365 days before date of visit to date of visit
297	2	638-639	[FBG] WAS BLOOD FOR FASTING BLOOD GUCOSE (FBG) TEST DRAWN ON THE DAY OF THE SAMPLED VISIT OR DURING THE 12 MONTHS PRIOR TO THE VISIT? -9 = Blank -7 = Not applicable, provider not sampled 1 = Yes 2 = None found within 12 months
298	3	640-642	[FBGRES] MOST RECENT RESULT FOR FASTING BLOOD GLUCOSE (FBG) TEST -9 = Blank -8 = Unknown -7 = Not applicable, provider not sampled 49-493 mg/dL

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
299	4	643-646	[DAYDFBG] DIFFERENCE IN DAYS BETWEEN VISIT DATE AND DATE OF FASTING BLOOD GLUCOSE (FBG) LAB RESULT -900 = Blank -800 = Unknown -700 = Not applicable, provider not sampled -365 to 0 = Up to 365 days before date of visit to date of visit
300	2	647-648	[SERUM] WAS BLOOD FOR SERUM CREATININE DRAWN ON THE DAY OF THE SAMPLED VISIT OR DURING THE 12 MONTHS PRIOR TO THE VISIT? -9 = Blank -7 = Not applicable, provider not sampled 1 = Yes 2 = None found within 12 months
301	5	649-653	[SERUMRESR] MOST RECENT RESULT FOR SERUM CREATININE (mg/dL) -9 = Blank -8 = Unknown -7 = Not applicable, provider not sampled 0.1 – 15.3 mg/dL
302	4	654-657	[DAYDSERUM] DIFFERENCE IN DAYS BETWEEN VISIT DATE AND DATE OF SERUM CREATININE LAB RESULT -900 = Blank -800 = Unknown -700 = Not applicable, provider not sampled -365 to 0 = Up to 365 days before date of visit to date of visit
**** THE FOLLOWING FIELDS SHOW WHETHER DATA WERE REPORTED ON THE PRF OR CALCULATED DURING DATA PROCESSING, OR WHETHER DATA WERE IMPUTED TO REPLACE BLANKS ****			
303	2	658-659	[AGEFLAG] Was patient age reported on the PRF or calculated during data processing based on date of visit and date of birth? -9 = Birth date imputed 0 = Calculated by NCHS 1 = Entered by respondent IMPUTED ITEMS 0 = Not imputed 1 = Imputed
304	1	660	[BDATEFL] Patient birth year
305	1	661	[SEXFL] Patient sex
306	1	662	[ETHNICFL] Patient ethnicity
307	1	663	[RACERFL] Patient race
308	1	664	[SENBEFL] Has patient been seen in your practice before?

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
309	1	665	[PASTFL] If yes, how many past visits in last 12 months?
310	1	666	[TIMEMDFL] Time spent with physician (minutes)
311	1	667	[HTWTFL] Did height or weight fall outside of acceptable ranges?

******END OF IMPUTED DATA ITEMS******

312 5 668-672 [PHYCODE] PHYSICIAN CODE - A unique code assigned to all records from a particular physician.
1-677

313 3 673-675 [PATCODE] PATIENT CODE - A number assigned to identify each individual record from a particular physician.
1-67

314 2 676-677 [SPECR] PHYSICIAN SPECIALTY RECODE, 14 GROUPS
This is a 14-group specialty variable that is consistent with the SPECR variable in previous survey years when similar groups were sampled.

01 = General and family practice	09 = Dermatology
03 = Internal medicine	10 = Urology
04 = Pediatrics	11 = Psychiatry
05 = General surgery	12 = Neurology
06 = Obstetrics and gynecology	13 = Ophthalmology
07 = Orthopedic surgery	14 = Otolaryngology
08 = Cardiovascular diseases	15 = All other

(Note: For SPECR, doctors of osteopathy (formerly stratum 02) have been aggregated with doctors of medicine according to their self-designated practice specialty, and therefore are not differentiated in the variable range. To isolate doctors of osteopathy from medical doctors using the Physician Specialty Recode variable, it is necessary to crosstabulate it with Type of Doctor located in position 679.)

315 1 678 [SPECCAT] PHYSICIAN SPECIALTY GROUP
(Recoded from internal data using categories on page 124.)
1 = Primary care specialty
2 = Surgical care specialty
3 = Medical care specialty

316 1 679 [MDDO] TYPE OF DOCTOR
1 = M.D. - Doctor of Medicine
2 = D.O. - Doctor of Osteopathy

317 1 680 [RETYPOFFR] TYPE OF OFFICE SETTING FOR THIS VISIT (Recoded)
1 = Private solo or group practice
2 = Other

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
318	2	681-682	[SOLO] DO YOU HAVE A SOLO PRACTICE, OR ARE YOU ASSOCIATED WITH OTHER PHYSICIANS IN A PARTNERSHIP, A GROUP PRACTICE, OR SOME OTHER WAY AT THIS VISIT LOCATION? -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Solo 2 = Non-solo
319	2	683-684	[EMPSTAT] ARE YOU A FULL OR PART OWNER, EMPLOYEE, OR INDEPENDENT CONTRACTOR AT THIS VISIT LOCATION? -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Full owner 2 = Part owner 3 = Employee 4 = Contractor
320	2	685-686	[OWNSR] WHO OWNS THE PRACTICE AT THIS VISIT LOCATION? (Recoded) -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Physician or physician group 2 = Medical/Academic health center; other hospital 3 = Insurance company, health plan, or HMO; other health care Corporation; other
321	2	687-688	[PATEVEN] DO YOU SEE PATIENTS IN THE OFFICE DURING THE EVENING OR ON WEEKENDS AT THIS VISIT LOCATION? -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes 2 = No DURING LAST NORMAL WEEK OF PRACTICE, DID YOU MAKE ENCOUNTERS OF THE FOLLOWING TYPES WITH PATIENTS:
322	2	689-690	[NHVISR] NURSING HOME VISITS -9 = Blank -8 = Unknown -6 = Refused to answer question 0 = No 1 = Yes

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
323	2	691-692	[HOMVISR] OTHER HOME VISITS -9 = Blank -8 = Unknown -6 = Refused to answer question 0 = No 1 = Yes
324	2	693-694	[HOSVISR] HOSPITAL VISITS -9 = Blank -8 = Unknown -6 = Refused to answer question 0 = No 1 = Yes
325	2	695-696	[TELCONR] TELEPHONE CONSULTS -9 = Blank -8 = Unknown -6 = Refused to answer question 0 = No 1 = Yes
326	2	697-698	[ECONR] INTERNET/EMAIL CONSULTS -9 = Blank -8 = Unknown -6 = Refused to answer question 0 = No 1 = Yes

NOTE: For items 327-388, in cases where the physician had more than one in-scope office location, the questions were asked for the location where the physician had the most office visit encounters during his or her last normal week of practice.

327	2	699-700	[EBILLANY] DOES YOUR PRACTICE SUBMIT ANY CLAIMS ELECTRONICALLY (ELECTRONIC BILLING)? -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes 2 = No
328	2	701-702	[EMEDREC] DOES YOUR PRACTICE USE AN ELECTRONIC HEALTH RECORD (EHR) OR ELECTRONIC MEDICAL RECORD (EMR) SYSTEM? Do not include billing records systems. -9 = Blank -8 = Don’t know -6 = Refused to answer question 1 = Yes, all electronic 2 = Yes, part paper and part electronic 3 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
329	2	703-704	[HHSMU] DOES YOUR CURRENT SYSTEM MEET MEANINGFUL CRITERIA AS DEFINED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
330	2	705-706	[EMRINS] AT YOUR PRACTICE, ARE THERE PLANS FOR INSTALLING A NEW EMR SYSTEM OR REPLACING THE CURRENT SYSTEM WITHIN THE NEXT 18 MONTHS? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No 3 = Maybe

IMPORTANT NOTE: Questions on features of a reporting location's computerized capabilities have changed over the years. The instrument format used in 2016 is slightly different than what was used in 2015 and previous years.

The current format is essentially similar to the recoded "R" variables used in 2010-2015. For example, in 2015, EDEMOG reflected the actual instrument format and EDEMOGR was a recoding of that format to match years 2010-2015 for trending purpose. The categories used with the recoded "R" variables were 1=Yes, 2=No, and 4=Yes, but turned off/not used. The 'Turned off/not used' category was dropped for 2016, so the only response options are yes and no. The "R" variable name was retained because the response categories are similar to those from 2010-2015 and they now reflect the actual instrument format as well. Please take note of these differences if using data from multiple years.

			PLEASE INDICATE WHETHER THE AMBULATORY REPORTING LOCATION HAS EACH OF THE FOLLOWING COMPUTERIZED CAPABILITIES AND HOW OFTEN THESE CAPABILITIES ARE USED: (APPLIES TO ITEMS 331-350)
331	2	707-708	[EDEMOGR] RECORDING PATIENT HISTORY AND DEMOGRAPHIC INFORMATION -9 = Blank -8 = Don't know -6 = Refused to answer question 1= Yes 2= No
332	2	709-710	[EPROLSTR] RECORDING PATIENT PROBLEM LIST -9 = Blank -8 = Don't know -6 = Refused to answer question 1= Yes 2= No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
333	2	711-712	[EPNOTESR] RECORDING CLINICAL NOTES -9 = Blank -8 = Don't know -6 = Refused to answer question 1= Yes 2= No
334	2	713-714	[EMEDALGR] RECORDING PATIENT'S MEDICATIONS AND ALLERGIES -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
335	2	715-716	[EMEDIDR] RECONCILING LISTS OF PATIENTS' MEDICATIONS TO IDENTIFY THE MOST ACCURATE LIST -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
336	2	717-718	[EREMINDR] REMINDERS FOR GUIDELINE-BASED INTERVENTIONS AND/OR SCREENING TESTS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
337	2	719-720	[ECPOER] ORDERING PRESCRIPTIONS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
338	2	721-722	[ESCRIPR] IF YES TO ORDERING PRESCRIPTIONS, ARE PRESCRIPTIONS SENT ELECTRONICALLY TO THE PHARMACY? -9 = Blank -8 = Don't know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
339	2	723-724	[EWARNR] IF YES TO ORDERING PRESCRIPTIONS, ARE WARNINGS OF DRUG INTERACTIONS OR CONTRAINDICATIONS PROVIDED? -9 = Blank -8 = Don't know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
340	2	725-726	[ECONTR] DO YOU PRESCRIBE CONTROLLED SUBSTANCES? -9 = Blank -8 = Don't know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
341	2	727-728	[ECONTSCRIPR] ARE PRESCRIPTIONS FOR CONTROLLED SUBSTANCES SENT ELECTRONICALLY? -9 = Blank -8 = Don't know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
342	2	729-730	[ECTOER] ORDERING LAB TESTS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
343	2	731-732	[ERESULTR] VIEWING LAB RESULTS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
344	2	733-734	[ERADIR] ORDERING RADIOLOGY TESTS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
345	2	735-736	[EIMGRESR] VIEWING IMAGING RESULTS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
346	2	737-738	[EIDPTR] IDENTIFYING PATIENTS DUE FOR PREVENTIVE OR FOLLOW-UP CARE IN ORDER TO SEND PATIENTS REMINDERS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
347	2	739-740	[EGENLISTR] GENERATING LISTS OF PATIENTS WITH PARTICULAR HEALTH CONDITIONS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
348	2	741-742	[EDATAREPR] PROVIDING DATA TO CREATE REPORTS ON CLINICAL CARE MEASURES FOR PATIENTS WITH SPECIFIC CHRONIC CONDITIONS (e.g. HbA1c FOR DIABETES) -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
349	2	743-744	[ESUMR] PROVIDING PATIENTS WITH CLINICAL SUMMARIES FOR EACH VISIT -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
350	2	745-746	[EMSGR] EXCHANGING SECURE MESSAGES WITH PATIENTS -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
351	2	747-748	[REFOUT] DO YOU REFER ANY OF YOUR PATIENTS TO A PROVIDER OUTSIDE OF YOUR OFFICE OR GROUP? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
352	2	749-750	[REF_ELE] HOW DO YOU SEND PATIENT HEALTH INFORMATION: ELECTRONICALLY (EHR, WEB PORTAL, OR ONLINE REGISTRIES)? -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
353	2	751-752	[REF_PAPER] HOW DO YOU SEND PATIENT HEALTH INFORMATION: VIA PAPER-BASED METHODS (FAX, eFAX, OR MAIL) -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
354	2	753-754	[NO_REF] HOW DO YOU SEND PATIENT HEALTH INFORMATION: WE DO NOT SEND ANY PATIENT HEALTH INFORMATION TO PROVIDERS OUTSIDE OF OUR OFFICE OR GROUP -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
355	2	755-756	[REFOUTHOWUNK] HOW DO YOU SEND PATIENT HEALTH INFORMATION: UNKNOWN -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
356	2	757-758	[REFOUTHOWREF] HOW DO YOU SEND PATIENT HEALTH INFORMATION: REFUSED TO ANSWER -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
357	2	759-760	[REFIN] DO YOU SEE PATIENTS REFERRED TO YOU BY PROVIDERS OUTSIDE OF YOUR OFFICE OR GROUP? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
358	2	761-762	[REC_ELE] HOW DO YOU RECEIVE PATIENT HEALTH INFORMATION: ELECTRONICALLY (EHR, WEB PORTAL, OR ONLINE REGISTRIES)? -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
359	2	763-764	[REC_PAPER] HOW DO YOU RECEIVE PATIENT HEALTH INFORMATION: VIA PAPER-BASED METHODS (FAX, eFAX, OR MAIL) -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
360	2	765-766	[NO_REC] HOW DO YOU RECEIVE PATIENT HEALTH INFORMATION: WE DO NOT RECEIVE ANY PATIENT HEALTH INFORMATION FROM PROVIDERS OUTSIDE OF OUR OFFICE OR GROUP -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
361	2	767-768	[REFINHOWUNK] HOW DO YOU RECEIVE PATIENT HEALTH INFORMATION: UNKNOWN 0 = Box is not marked 1 = Box is marked 2 = Entire item blank
362	2	769-770	[REFINHOWREF] HOW DO YOU RECEIVE PATIENT HEALTH INFORMATION: REFUSED TO ANSWER -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
363	2	771-772	[ESHARE] DO YOU SEND OR RECEIVE PATIENT HEALTH INFORMATION ELECTRONICALLY? ELECTRONICALLY DOES NOT INCLUDE SCANNED OR PDF DOCUMENTS FROM FAX, eFAX, OR MAIL. -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
364	2	773-774	[ESHARES] DO YOU ELECTRONICALLY SEND PATIENT HEALTH INFORMATION TO ANOTHER PROVIDER WHOSE EHR SYSTEM IS DIFFERENT FROM YOUR OWN? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
365	2	775-776	[ESHARER] DO YOU ELECTRONICALLY RECEIVE PATIENT HEALTH INFORMATION FROM ANOTHER PROVIDER WHOSE EHR SYSTEM IS DIFFERENT FROM YOUR OWN? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Yes 2 = No
366	2	777-778	[DISCHSR_SEND] DO YOU ELECTRONICALLY SEND OR RECEIVE HOSPITAL DISCHARGE SUMMARIES TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? – SEND ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
367	2	779-780	[DISCHSR_REC] DO YOU ELECTRONICALLY SEND OR RECEIVE HOSPITAL DISCHARGE SUMMARIES TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? – RECEIVE ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
368	2	781-782	[DISCHSR_NO] DO YOU ELECTRONICALLY SEND OR RECEIVE HOSPITAL DISCHARGE SUMMARIES TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? – DO NOT SEND OR RECEIVE ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
369	2	783-784	[DISCHSR_UNK] DO YOU ELECTRONICALLY SEND OR RECEIVE HOSPITAL DISCHARGE SUMMARIES TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? – UNKNOWN -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
370	2	785-786	DISCHSR_REF] DO YOU ELECTRONICALLY SEND OR RECEIVE HOSPITAL DISCHARGE SUMMARIES TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? – REFUSED TO ANSWER -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
371	2	787-788	[EEDSR_SEND] DO YOU ELECTRONICALLY SEND OR RECEIVE EMERGENCY DEPARTMENT NOTIFICATIONS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION – SEND ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
372	2	789-790	[EEDSR_REC] DO YOU ELECTRONICALLY SEND OR RECEIVE EMERGENCY DEPARTMENT NOTIFICATIONS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION – RECEIVED ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
373	2	791-792	[EEDSR_NO] DO YOU ELECTRONICALLY SEND OR RECEIVE EMERGENCY DEPARTMENT NOTIFICATIONS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION – DO NOT SEND OR RECEIVE ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
374	2	793-794	[EEDSR_UNK] DO YOU ELECTRONICALLY SEND OR RECEIVE EMERGENCY DEPARTMENT NOTIFICATIONS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION – UNKNOWN -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
375	2	795-796	[EEDSR_REF] DO YOU ELECTRONICALLY SEND OR RECEIVE EMERGENCY DEPARTMENT NOTIFICATIONS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION – REFUSED TO ANSWER -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
376	2	797-798	[ESUMCSR_SEND] DO YOU ELECTRONICALLY SEND OR RECEIVE SUMMARY OF CARE RECORDS FOR TRANSITIONS OF CARE OR REFERRALS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? --SEND ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
377	2	799-800	[ESUMCSR_REC] DO YOU ELECTRONICALLY SEND OR RECEIVE SUMMARY OF CARE RECORDS FOR TRANSITIONS OF CARE OR REFERRALS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? --RECEIVE ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
378	2	801-802	[ESUMCSR_NO] DO YOU ELECTRONICALLY SEND OR RECEIVE SUMMARY OF CARE RECORDS FOR TRANSITIONS OF CARE OR REFERRALS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? –DO NOT SEND OR RECEIVE ELECTRONICALLY -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
379	2	803-804	[ESUMCSR_UNK] DO YOU ELECTRONICALLY SEND OR RECEIVE SUMMARY OF CARE RECORDS FOR TRANSITIONS OF CARE OR REFERRALS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? –UNKNOWN -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
380	2	805-806	[ESUMCSR_REF] DO YOU ELECTRONICALLY SEND OR RECEIVE SUMMARY OF CARE RECORDS FOR TRANSITIONS OF CARE OR REFERRALS TO OR FROM PROVIDERS OUTSIDE OF YOUR MEDICAL ORGANIZATION? –REFUSED TO ANSWER -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
381	2	807-808	[PTONLINE_VIEW] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – VIEW THEIR MEDICAL RECORD ONLINE -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
382	2	809-810	[PTONLINE_DOWN] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – DOWNLOAD AND TRANSMIT HEALTH INFORMATION IN THE ELECTRONIC MEDICAL RECORD TO THEIR PERSONAL FILES -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
383	2	811-812	[PTONLINE_REQ] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – REQUEST CORRECTIONS TO THEIR ELECTRONIC MEDICAL RECORD -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
384	2	813-814	[PTONLINE_ENTER] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – ENTER THEIR HEALTH INFORMATION ONLINE (E.G. WEIGHT, SYMPTOMS) -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
385	2	815-816	[PTONLINE_UPLOAD] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – UPLOAD THEIR DATA FROM SELF-MONITORING DEVICES (E.G. BLOOD GLUCOSE READINGS) -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
386	2	817-818	[PTONLINE_NO] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – NONE OF THE ABOVE -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
387	2	819-820	[PTONLINE_UNK] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – UNKNOWN -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked
388	2	821-822	[PTONLINE_REF] CAN PATIENTS SEEN AT THE REPORTING LOCATION DO THE FOLLOWING ONLINE ACTIVITIES? – REFUSED TO ANSWER -9 = Entire item blank -7 = Not applicable 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
389	2	823-824	[PRMCARER] Roughly, what percent of your patient care revenue comes from Medicare? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
390	2	825-826	[PRMAIDR] Roughly, what percent of your patient care revenue comes from Medicaid? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
391	2	827-828	[PRPRVTR] Roughly, what percent of your patient care revenue comes from private insurance? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
392	2	829-830	[PRPATR] Roughly, what percent of your patient care revenue comes from patient payments? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
393	2	831-832	[PROTHR] Roughly, what percent of your patient care revenue comes from other sources? (including charity, research, Champus, VA, etc.) -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
394	2	833-834	[PRMANR] Roughly, what percentage of the patient care revenue received by this practice comes from (these) managed care contracts? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
395	2	835-836	[REVFFSR] Roughly, what percent of your patient care revenue comes from usual, customary, and reasonable fee-for-service? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
396	2	837-838	[REVCAPR] Roughly, what percent of your patient care revenue comes from capitation? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
397	2	839-840	[REVCASER] Roughly, what percent of your patient care revenue comes from case rates (e.g. package pricing/episode of care)? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent
398	2	841-842	[REVOTHR] Roughly, what percent of your patient care revenue comes from other sources? -9 = Blank -8 = Don't know -6 = Refused to answer question 1 = Less than or equal to 25 percent 2 = 26-50 percent 3 = 51-75 percent 4 = More than 75 percent

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
399	2	843-844	[ACEPTNEW] Are you currently accepting “new” patients into your practice? -9 = Blank -8 = Don’t know -6 = Refused to answer question 1 = Yes 2 = No
400	2	845-846	[CAPITATE] From those “new” patients, which of the following types of payment do you accept? - Capitated private insurance -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
401	2	847-848	[NOCAP] From those “new” patients, which of the following types of payment do you accept? – Non-capitated private insurance -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
402	2	849-850	[PRIVATE] (Derived from responses to CAPITATE and NOCAP) From those “new” patients, which of the following types of payment do you accept? – Private insurance (capitated or non-capitated) -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
403	2	851-852	[NMEDCARE] From those “new” patients, which of the following types of payment do you accept? – Medicare -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
404	2	853-854	[NMEDCAID] From those “new” patients, which of the following types of payment do you accept? – Medicaid -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
405	2	855-856	[NWORKCMP] From those “new” patients, which of the following types of payment do you accept? – Workers compensation -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
406	2	857-858	[NSELFPAY] From those “new” patients, which of the following types of payment do you accept? – Self-pay -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
407	2	859-860	[NNOCHRGE] From those “new” patients, which of the following types of payment do you accept? – No charge -9 = Blank -8 = Don’t know -7 = Not applicable -6 = Refused to answer question 1 = Yes 2 = No
408	2	861-862	[PHYSCOMP] WHICH OF THE FOLLOWING METHODS BEST DESCRIBES YOUR BASIC COMPENSATION? -9 = Blank -8 = Don’t know -6 = Refused to answer question 1 = Fixed salary 2 = Share of practice billings or workload 3 = Mix of salary and share of billings or other measures of performance(e.g., your own billings, practice financial performance, quality measures, practice profiling) 4 = Shift, hourly or other time-based payment 5 = Other

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			CLINICAL PRACTICES MAY TAKE VARIOUS FACTORS INTO ACCOUNT WHEN DETERMINING THE COMPENSATION (SALARY, BONUS, PAY RATE, ETC.) PAID TO THE PHYSICIANS IN THE PRACTICE. PLEASE INDICATE WHETHER THE PRACTICE EXPLICITLY CONSIDERS EACH OF THE FOLLOWING FACTORS IN DETERMINING YOUR COMPENSATION:
409	2	863-864	[COMPPROD] FACTORS THAT REFLECT YOUR OWN PRODUCTIVITY -9 = Entire item blank 0 = Box is not marked 1 = Box is marked
410	2	865-866	[COMPSAT] RESULTS OF SATISFACTION SURVEYS FROM YOUR OWN PATIENTS -9 = Entire item blank 0 = Box is not marked 1 = Box is marked
411	2	867-868	[COMPQUAL] SPECIFIC MEASURES OF QUALITY, SUCH AS RATES OF PREVENTIVE SERVICES FOR YOUR PATIENTS -9 = Entire item blank 0 = Box is not marked 1 = Box is marked
412	2	869-870	[COMPDROF] RESULTS OF PRACTICE PROFILING, THAT IS, COMPARING YOUR PATTERN OF USING MEDICAL RESOURCES WITH THAT OF OTHER PHYSICIANS -9 = Entire item blank 0 = Box is not marked 1 = Box is marked
413	2	871-872	[COMPFIN] THE OVERALL FINANCIAL PERFORMANCE OF THE PRACTICE -9 = Entire item blank 0 = Box is not marked 1 = Box is marked
414	2	873-874	[COMPUNK] UNKNOWN -9 = Entire item blank 0 = Box is not marked 1 = Box is marked
415	2	875-876	[COMPREF] REFUSED TO ANSWER -9 = Entire item blank 0 = Box is not marked 1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
416	2	877-878	[SASDAPPT] Does your practice set time aside for same day appointments?

NOTE: There was a change for 2015 in how this question and the following question SDAPPTPCT were asked. In previous years, the order of these questions was reversed and they were asked independently, meaning that a practice that reported a percentage of visits as same day appointments could also answer "no" (did not set aside time for same day appointments). One might conjecture that the same day appointments reported in such cases might have been due to last minute cancellations or other factors, as opposed to having specific time set aside for same day appointments.

For 2015, the survey instrument underwent a change, such that SASDAPPT was asked first, and ONLY physicians who responded "yes" to that question (does your practice set aside time for same day appointments?) were asked about the percentage of visits that were same day appointments. For this reason the results from SDAPPTPCT will not be comparable with previous years of data, and, in fact, substantial differences can be seen when comparing percentages across years. To further emphasize the differences, the item name has been changed from SDAPPT used in previous years to SDAPPTPCT in 2015.

-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes
2 = No

417	3	879-881	[SDAPPTPCT] If your practice sets aside time for same day appointments, what percent of your daily visits are same day appointments? -9 = Blank -7 = Not applicable (practice does not set aside time for same day appointments) -6 = Refused to answer question 0-100
418	2	882-883	[APPTTIME] On average, about how long does it take to get an appointment for a routine medical exam? -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Within 1 week 2 = 1-2 weeks 3 = 3-4 weeks 4 = 1-2 months 5 = 3 or more months 6 = Do not provide routine exams
419	1	884	[REGIONOFF] GEOGRAPHIC REGION (Based on location where majority of visit records were sampled) 1 = Northeast 2 = Midwest 3 = South 4 = West

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
420	1	885	[MSA] METROPOLITAN/NON-METROPOLITAN STATUS (Based on physician location in conjunction with the definition of the Bureau of the Census and the U.S. Office of Management and Budget.) 1 = MSA (Metropolitan Statistical Area) 2 = Not MSA (includes micropolitan statistical areas)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #1

NOTE: Starting with the 2006 data release, all drug codes based on entry name (using NCHS' standard classification system) were also assigned a unique generic drug code from Multum's Lexicon Drug Database, where possible. The structure of the Multum database is such that multiple ingredient drugs are assigned a single generic drug code encompassing all of a drug's ingredients rather than being assigned generic drug codes for each ingredient, as in past years of NAMCS drug data. All Multum codes start with the letter "d" but there were some drugs reported in NAMCS that could not be assigned a code in Multum. For 2006 and 2007, these received a prefix of either "a" (when ingredients could be determined) or "c" (when ingredients could not be determined). Beginning with 2008, the use of "a" and "c" codes was replaced with "n" codes. For more on the structure of the drug data (including information on therapeutic class and drug ingredients), please see page 32.

421	6	886-891	[DRUGID1] DRUG ID (See page 164 for more information.) a07001-a92507 = NCHS code (for drugs not found in Multum but for which ingredients could be determined, for drugs added to the database for survey years 2006 and 2007) c00001-c00898, c00900-c92511 = NCHS code (for drugs not found in Multum and with undetermined ingredients) c00899 – Undetermined pharmaceutical aid d00001-d08524 = Multum code n00000-n13006 = NCHS code (for drugs not found in Multum that were added to the database beginning with survey year 2008)
422	1	892	[PRESCR1] PRESCRIPTION STATUS CODE 1 = Prescription Drug 2 = Nonprescription Drug 3 = Undetermined 4 = Illicit [not used in NAMCS] 5 = Both Prescription and Over-the-Counter
423	1	893	[CONTSUB1] CONTROLLED SUBSTANCE STATUS CODE 1 = Schedule I (Research Only) 2 = Schedule II 3 = Schedule III 4 = Schedule IV 5 = Schedule V 6 = No Control 7 = Undetermined 8 = Multiple Schedules
424	1	894	[COMSTAT1] COMPOSITION STATUS CODE 1 = Single Entity Drug 2 = Combination Drug 3 = Undetermined

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
425	3	895-897	[RX1CAT1] MULTUM DRUG CATEGORY # 1

Reflects the most detailed therapeutic level to which the drug can be classified. For some drugs, Multum Level 1 (broadest level) is the most detailed, while others can be coded to Level 2, but the majority can be coded to Level 3 (most detailed level). For more on the Multum classification system, please see page 32. The complete Multum classification is shown in Appendix III.

" " = Blank/Not applicable
001 - 899 = Drug category

426	3	898-900	[RX1CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
427	3	901-903	[RX1CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
428	3	904-906	[RX1CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.

DRUG CATEGORY LEVELS

See RX1CAT1 for general coding conventions that apply to all Multum drug categories. Complete Multum classification scheme is shown in Appendix III.

429	3	907-909	[RX1V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
430	3	910-912	[RX1V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
431	3	913-915	[RX1V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
432	3	916-918	[RX1V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
433	3	919-921	[RX1V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
434	3	922-924	[RX1V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
435	3	925-927	[RX1V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
436	3	928-930	[RX1V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
437	3	931-933	[RX1V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
438	3	934-936	[RX1V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
439	3	937-939	[RX1V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
440	3	940-942	[RX1V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #2
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
441	6	943-948	[DRUGID2] DRUG ID
442	1	949	[PRESCR2] PRESCRIPTION STATUS CODE
443	1	950	[CONTSUB2] CONTROLLED SUBSTANCE STATUS CODE
444	1	951	[COMSTAT2] COMPOSITION STATUS CODE
445	3	952-954	[RX2CAT1] MULTUM DRUG CATEGORY # 1
446	3	955-957	[RX2CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
447	3	958-960	[RX2CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
448	3	961-963	[RX2CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
449	3	964-966	[RX2V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
450	3	967-969	[RX2V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
451	3	970-972	[RX2V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
452	3	973-975	[RX2V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
453	3	976-978	[RX2V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
454	3	979-981	[RX2V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
455	3	982-984	[RX2V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
456	3	985-987	[RX2V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
457	3	988-990	[RX2V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
458	3	991-993	[RX2V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
459	3	994-996	[RX2V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
460	3	997-999	[RX2V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #3
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
461	6	1000-1005	[DRUGID3] DRUG ID
462	1	1006	[PRESCR3] PRESCRIPTION STATUS CODE
463	1	1007	[CONTSUB3] CONTROLLED SUBSTANCE STATUS CODE
464	1	1008	[COMSTAT3] COMPOSITION STATUS CODE
465	3	1009-1011	[RX3CAT1] MULTUM DRUG CATEGORY # 1
466	3	1012-1014	[RX3CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
467	3	1015-1017	[RX3CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
468	3	1018-1020	[RX3CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
469	3	1021-1023	[RX3V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
470	3	1024-1026	[RX3V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
471	3	1027-1029	[RX3V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
472	3	1030-1032	[RX3V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
473	3	1033-1035	[RX3V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
474	3	1036-1038	[RX3V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
475	3	1039-1041	[RX3V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
476	3	1042-1044	[RX3V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
477	3	1045-1047	[RX3V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
478	3	1048-1050	[RX3V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
479	3	1051-1053	[RX3V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
480	3	1054-1056	[RX3V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #4
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
481	6	1057-1062	[DRUGID4] DRUG ID
482	1	1063	[PRESCR4] PRESCRIPTION STATUS CODE
483	1	1064	[CONTSUB4] CONTROLLED SUBSTANCE STATUS CODE
484	1	1065	[COMSTAT4] COMPOSITION STATUS CODE
485	3	1066-1068	[RX4CAT1] MULTUM DRUG CATEGORY # 1
486	3	1069-1071	[RX4CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
487	3	1072-1074	[RX4CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
488	3	1075-1077	[RX4CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
489	3	1078-1080	[RX4V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
490	3	1081-1083	[RX4V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
491	3	1084-1086	[RX4V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
492	3	1087-1089	[RX4V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
493	3	1090-1092	[RX4V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
494	3	1093-1095	[RX4V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
495	3	1096-1098	[RX4V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
496	3	1099-1101	[RX4V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
497	3	1102-1104	[RX4V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
498	3	1105-1107	[RX4V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
499	3	1108-1110	[RX4V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
500	3	1111-1113	[RX4V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #5
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
501	6	1114-1119	[DRUGID5] DRUG ID
502	1	1120	[PRESCR5] PRESCRIPTION STATUS CODE
503	1	1121	[CONTSUB5] CONTROLLED SUBSTANCE STATUS CODE
504	1	1122	[COMSTAT5] COMPOSITION STATUS CODE
505	3	1123-1125	[RX5CAT1] MULTUM DRUG CATEGORY # 1
506	3	1126-1128	[RX5CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
507	3	1129-1131	[RX5CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
508	3	1132-1134	[RX5CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
509	3	1135-1137	[RX5V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
510	3	1138-1140	[RX5V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
511	3	1141-1143	[RX5V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
512	3	1144-1146	[RX5V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
513	3	1147-1149	[RX5V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
514	3	1150-1152	[RX5V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
515	3	1153-1155	[RX5V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
516	3	1156-1158	[RX5V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
517	3	1159-1161	[RX5V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
518	3	1162-1164	[RX5V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
519	3	1165-1167	[RX5V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
520	3	1168-1170	[RX5V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #6
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
521	6	1171-1176	[DRUGID6] DRUG ID
522	1	1177	[PRESCR6] PRESCRIPTION STATUS CODE
523	1	1178	[CONTSUB6] CONTROLLED SUBSTANCE STATUS CODE
524	1	1179	[COMSTAT6] COMPOSITION STATUS CODE
525	3	1180-1182	[RX6CAT1] MULTUM DRUG CATEGORY # 1
526	3	1183-1185	[RX6CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
527	3	1186-1188	[RX6CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
528	3	1189-1191	[RX6CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
529	3	1192-1194	[RX6V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
530	3	1195-1197	[RX6V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
531	3	1198-1200	[RX6V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
532	3	1201-1203	[RX6V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
533	3	1204-1206	[RX6V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
534	3	1207-1209	[RX6V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
535	3	1210-1212	[RX6V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
536	3	1213-1215	[RX6V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
537	3	1216-1218	[RX6V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
538	3	1219-1221	[RX6V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
539	3	1222-1224	[RX6V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
540	3	1225-1227	[RX6V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #7
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
541	6	1228-1233	[DRUGID7] DRUG ID
542	1	1234	[PRESCR7] PRESCRIPTION STATUS CODE
543	1	1235	[CONTSUB7] CONTROLLED SUBSTANCE STATUS CODE
544	1	1236	[COMSTAT7] COMPOSITION STATUS CODE
545	3	1237-1239	[RX7CAT1] MULTUM DRUG CATEGORY # 1
546	3	1240-1242	[RX7CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
547	3	1243-1245	[RX7CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
548	3	1246-1248	[RX7CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
549	3	1249-1251	[RX7V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
550	3	1252-1254	[RX7V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
551	3	1255-1257	[RX7V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
552	3	1258-1260	[RX7V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
553	3	1261-1263	[RX7V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
554	3	1264-1266	[RX7V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
555	3	1267-1269	[RX7V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
556	3	1270-1272	[RX7V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
557	3	1273-1275	[RX7V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
558	3	1276-1278	[RX7V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
559	3	1279-1281	[RX7V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
560	3	1282-1284	[RX7V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #8
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
561	6	1285-1290	[DRUGID8] DRUG ID
562	1	1291	[PRESCR8] PRESCRIPTION STATUS CODE
563	1	1292	[CONTSUB8] CONTROLLED SUBSTANCE STATUS CODE
564	1	1293	[COMSTAT8] COMPOSITION STATUS CODE
565	3	1294-1296	[RX8CAT1] MULTUM DRUG CATEGORY # 1
566	3	1297-1299	[RX8CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
567	3	1300-1302	[RX8CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
568	3	1303-1305	[RX8CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
569	3	1306-1308	[RX8V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
570	3	1309-1311	[RX8V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
571	3	1312-1314	[RX8V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
572	3	1315-1317	[RX8V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
573	3	1318-1320	[RX8V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
574	3	1321-1323	[RX8V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
575	3	1324-1326	[RX8V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
576	3	1327-1329	[RX8V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
577	3	1330-1332	[RX8V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
578	3	1333-1335	[RX8V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
579	3	1336-1338	[RX8V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
580	3	1339-1341	[RX8V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #9
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
581	6	1342-1347	[DRUGID9] DRUG ID
582	1	1348	[PRESCR9] PRESCRIPTION STATUS CODE
583	1	1349	[CONTSUB9] CONTROLLED SUBSTANCE STATUS CODE
584	1	1350	[COMSTAT9] COMPOSITION STATUS CODE
585	3	1351-1353	[RX9CAT1] MULTUM DRUG CATEGORY # 1
586	3	1354-1356	[RX9CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
587	3	1357-1359	[RX9CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
588	3	1360-1362	[RX9CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
589	3	1363-1365	[RX9V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
590	3	1366-1368	[RX9V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
591	3	1369-1371	[RX9V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
592	3	1372-1374	[RX9V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
593	3	1375-1377	[RX9V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
594	3	1378-1380	[RX9V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
595	3	1381-1383	[RX9V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
596	3	1384-1386	[RX9V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
597	3	1387-1389	[RX9V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
598	3	1390-1392	[RX9V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
599	3	1393-1395	[RX9V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
600	3	1396-1398	[RX9V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #10
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
601	6	1399-1404	[DRUGID10] DRUG ID
602	1	1405	[PRESCR10] PRESCRIPTION STATUS CODE
603	1	1406	[CONTSUB10] CONTROLLED SUBSTANCE STATUS CODE
604	1	1407	[COMSTAT10] COMPOSITION STATUS CODE
605	3	1408-1410	[RX10CAT1] MULTUM DRUG CATEGORY # 1
606	3	1411-1413	[RX10CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
607	3	1414-1416	[RX10CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
608	3	1417-1419	[RX10CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
609	3	1420-1422	[RX10V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
610	3	1423-1425	[RX10V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
611	3	1426-1428	[RX10V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
612	3	1429-1431	[RX10V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
613	3	1432-1434	[RX10V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
614	3	1435-1437	[RX10V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
615	3	1438-1440	[RX10V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
616	3	1441-1443	[RX10V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
617	3	1444-1446	[RX10V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
618	3	1447-1449	[RX10V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
619	3	1450-1452	[RX10V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
620	3	1453-1455	[RX10V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #11
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
621	6	1456-1461	[DRUGID11] DRUG ID
622	1	1462	[PRESCR11] PRESCRIPTION STATUS CODE
623	1	1463	[CONTSUB11] CONTROLLED SUBSTANCE STATUS CODE
624	1	1464	[COMSTAT11] COMPOSITION STATUS CODE
625	3	1465-1467	[RX11CAT1] MULTUM DRUG CATEGORY # 1
626	3	1468-1470	[RX11CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
627	3	1471-1473	[RX11CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
628	3	1474-1476	[RX11CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
629	3	1477-1479	[RX11V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
630	3	1480-1482	[RX11V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
631	3	1483-1485	[RX11V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
632	3	1486-1488	[RX11V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
633	3	1489-1491	[RX11V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
634	3	1492-1494	[RX11V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
635	3	1495-1497	[RX11V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
636	3	1498-1500	[RX11V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
637	3	1501-1503	[RX11V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
638	3	1504-1506	[RX11V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
639	3	1507-1509	[RX11V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
640	3	1510-1512	[RX11V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #12
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
641	6	1513-1518	[DRUGID12] DRUG ID
642	1	1519	[PRESCR12] PRESCRIPTION STATUS CODE
643	1	1520	[CONTSUB12] CONTROLLED SUBSTANCE STATUS CODE
644	1	1521	[COMSTAT12] COMPOSITION STATUS CODE
645	3	1522-1524	[RX12CAT1] MULTUM DRUG CATEGORY # 1
646	3	1525-1527	[RX12CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
647	3	1528-1530	[RX12CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
648	3	1531-1533	[RX12CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
649	3	1534-1536	[RX12V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
650	3	1537-1539	[RX12V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
651	3	1540-1542	[RX12V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
652	3	1543-1545	[RX12V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
653	3	1546-1548	[RX12V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
654	3	1549-1551	[RX12V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
655	3	1552-1554	[RX12V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
656	3	1555-1557	[RX12V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
657	3	1558-1560	[RX12V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
658	3	1561-1563	[RX12V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
659	3	1564-1566	[RX12V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
660	3	1567-1569	[RX12V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #13
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
661	6	1570-1575	[DRUGID13] DRUG ID
662	1	1576	[PRESCR13] PRESCRIPTION STATUS CODE
663	1	1577	[CONTSUB13] CONTROLLED SUBSTANCE STATUS CODE
664	1	1578	[COMSTAT13] COMPOSITION STATUS CODE
665	3	1579-1581	[RX13CAT1] MULTUM DRUG CATEGORY # 1
666	3	1582-1584	[RX13CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
667	3	1585-1587	[RX13CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
668	3	1588-1590	[RX13CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
669	3	1591-1593	[RX13V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
670	3	1594-1596	[RX13V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
671	3	1597-1599	[RX13V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
672	3	1600-1602	[RX13V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
673	3	1603-1605	[RX13V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
674	3	1606-1608	[RX13V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
675	3	1609-1611	[RX13V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
676	3	1612-1614	[RX13V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
677	3	1615-1617	[RX13V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
678	3	1618-1620	[RX13V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
679	3	1621-1623	[RX13V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
680	3	1624-1626	[RX13V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #14
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
681	6	1627-1632	[DRUGID14] DRUG ID
682	1	1633	[PRESCR14] PRESCRIPTION STATUS CODE
683	1	1634	[CONTSUB14] CONTROLLED SUBSTANCE STATUS CODE
684	1	1635	[COMSTAT14] COMPOSITION STATUS CODE
685	3	1636-1638	[RX14CAT1] MULTUM DRUG CATEGORY # 1
686	3	1639-1641	[RX14CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
687	3	1642-1644	[RX14CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
688	3	1645-1647	[RX14CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
689	3	1648-1650	[RX14V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
690	3	1651-1653	[RX14V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
691	3	1654-1656	[RX14V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
692	3	1657-1659	[RX14V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
693	3	1660-1662	[RX14V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
694	3	1663-1665	[RX14V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
695	3	1666-1668	[RX14V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
696	3	1669-1671	[RX14V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
697	3	1672-1674	[RX14V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
698	3	1675-1677	[RX14V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
699	3	1678-1680	[RX14V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
700	3	1681-1683	[RX14V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #15
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
701	6	1684-1689	[DRUGID15] DRUG ID
702	1	1690	[PRESCR15] PRESCRIPTION STATUS CODE
703	1	1691	[CONTSUB15] CONTROLLED SUBSTANCE STATUS CODE
704	1	1692	[COMSTAT15] COMPOSITION STATUS CODE
705	3	1693-1695	[RX15CAT1] MULTUM DRUG CATEGORY # 1
706	3	1696-1698	[RX15CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
707	3	1699-1701	[RX15CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
708	3	1702-1704	[RX15CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
709	3	1705-1707	[RX15V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
710	3	1708-1710	[RX15V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
711	3	1711-1713	[RX15V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
712	3	1714-1716	[RX15V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
713	3	1717-1719	[RX15V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
714	3	1720-1722	[RX15V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
715	3	1723-1725	[RX15V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
716	3	1726-1728	[RX15V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
717	3	1729-1731	[RX15V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
718	3	1732-1734	[RX15V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
719	3	1735-1737	[RX15V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
720	3	1738-1740	[RX15V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #16
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
721	6	1741-1746	[DRUGID16] DRUG ID
722	1	1747	[PRESCR16] PRESCRIPTION STATUS CODE
723	1	1748	[CONTSUB16] CONTROLLED SUBSTANCE STATUS CODE
724	1	1749	[COMSTAT16] COMPOSITION STATUS CODE
725	3	1750-1752	[RX16CAT1] MULTUM DRUG CATEGORY # 1
726	3	1753-1755	[RX16CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
727	3	1756-1758	[RX16CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
728	3	1759-1761	[RX16CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
729	3	1762-1764	[RX16V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
730	3	1765-1767	[RX16V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
731	3	1768-1770	[RX16V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
732	3	1771-1773	[RX16V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
733	3	1774-1776	[RX16V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
734	3	1777-1779	[RX16V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
735	3	1780-1782	[RX16V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
736	3	1783-1785	[RX16V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
737	3	1786-1788	[RX16V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
738	3	1789-1791	[RX16V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
739	3	1792-1794	[RX16V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
740	3	1795-1797	[RX16V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #17
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
741	6	1798-1803	[DRUGID17] DRUG ID
742	1	1804	[PRESCR17] PRESCRIPTION STATUS CODE
743	1	1805	[CONTSUB17] CONTROLLED SUBSTANCE STATUS CODE
744	1	1806	[COMSTAT17] COMPOSITION STATUS CODE
745	3	1807-1809	[RX17CAT1] MULTUM DRUG CATEGORY # 1
746	3	1810-1812	[RX17CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
747	3	1813-1815	[RX17CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
748	3	1816-1818	[RX17CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
749	3	1819-1821	[RX17V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
750	3	1822-1824	[RX17V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
751	3	1825-1827	[RX17V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
752	3	1828-1830	[RX17V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
753	3	1831-1833	[RX17V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
754	3	1834-1836	[RX17V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
755	3	1837-1839	[RX17V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
756	3	1840-1842	[RX17V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
757	3	1843-1845	[RX17V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
758	3	1846-1848	[RX17V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
759	3	1849-1851	[RX17V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
760	3	1852-1854	[RX17V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #18
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
761	6	1855-1860	[DRUGID18] DRUG ID
762	1	1861	[PRESCR18] PRESCRIPTION STATUS CODE
763	1	1862	[CONTSUB18] CONTROLLED SUBSTANCE STATUS CODE
764	1	1863	[COMSTAT18] COMPOSITION STATUS CODE
765	3	1864-1866	[RX18CAT1] MULTUM DRUG CATEGORY # 1
766	3	1867-1869	[RX18CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
767	3	1870-1872	[RX18CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
768	3	1873-1875	[RX18CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
769	3	1876-1878	[RX18V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
770	3	1879-1881	[RX18V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
771	3	1882-1884	[RX18V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
772	3	1885-1887	[RX18V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
773	3	1888-1890	[RX18V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
774	3	1891-1893	[RX18V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
775	3	1894-1896	[RX18V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
776	3	1897-1899	[RX18V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
777	3	1900-1902	[RX18V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
778	3	1903-1905	[RX18V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
778	3	1906-1908	[RX18V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
780	3	1909-1911	[RX18V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #19
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
781	6	1912-1917	[DRUGID19] DRUG ID
782	1	1918	[PRESCR19] PRESCRIPTION STATUS CODE
783	1	1919	[CONTSUB19] CONTROLLED SUBSTANCE STATUS CODE
784	1	1920	[COMSTAT19] COMPOSITION STATUS CODE
785	3	1921-1923	[RX19CAT1] MULTUM DRUG CATEGORY # 1
786	3	1924-1926	[RX19CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
787	3	1927-1929	[RX19CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
788	3	1930-1932	[RX19CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
789	3	1933-1935	[RX19V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
790	3	1936-1938	[RX19V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
791	3	1939-1941	[RX19V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
792	3	1942-1944	[RX19V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
793	3	1945-1947	[RX19V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
794	3	1948-1950	[RX19V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
795	3	1951-1953	[RX19V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
796	3	1954-1956	[RX19V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
797	3	1957-1959	[RX19V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
798	3	1960-1962	[RX19V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
799	3	1963-1965	[RX19V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
800	3	1966-1968	[RX19V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #20
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
801	6	1969-1974	[DRUGID20] DRUG ID
802	1	1975	[PRESCR20] PRESCRIPTION STATUS CODE
803	1	1976	[CONTSUB20] CONTROLLED SUBSTANCE STATUS CODE
804	1	1977	[COMSTAT20] COMPOSITION STATUS CODE
805	3	1978-1980	[RX20CAT1] MULTUM DRUG CATEGORY # 1
806	3	1981-1983	[RX20CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
807	3	1984-1986	[RX20CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
808	3	1987-1989	[RX20CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
809	3	1990-1992	[RX20V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
810	3	1993-1995	[RX20V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
811	3	1996-1998	[RX20V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
812	3	1999-2001	[RX20V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
813	3	2002-2004	[RX20V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
814	3	2005-2007	[RX20V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
815	3	2008-2010	[RX20V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
816	3	2011-2013	[RX20V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
817	3	2014-2016	[RX20V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
818	3	2017-2019	[RX20V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
819	3	2020-2022	[RX20V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
820	3	2023-2025	[RX20V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #21
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
821	6	2026-2031	[DRUGID21] DRUG ID
822	1	2032	[PRESCR21] PRESCRIPTION STATUS CODE
823	1	2033	[CONTSUB21] CONTROLLED SUBSTANCE STATUS CODE
824	1	2034	[COMSTAT21] COMPOSITION STATUS CODE
825	3	2035-2037	[RX21CAT1] MULTUM DRUG CATEGORY # 1
826	3	2038-2040	[RX21CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
827	3	2041-2043	[RX21CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
828	3	2044-2046	[RX21CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
829	3	2047-2049	[RX21V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
830	3	2050-2052	[RX21V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
831	3	2053-2055	[RX21V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
832	3	2056-2058	[RX21V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
833	3	2059-2061	[RX21V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
834	3	2062-2064	[RX21V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
835	3	2065-2067	[RX21V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
836	3	2068-2070	[RX21V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
837	3	2071-2073	[RX21V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
838	3	2074-2076	[RX21V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
839	3	2077-2079	[RX21V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
840	3	2080-2082	[RX21V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #22
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
841	6	2083-2088	[DRUGID22] DRUG ID
842	1	2089	[PRESCR22] PRESCRIPTION STATUS CODE
843	1	2090	[CONTSUB22] CONTROLLED SUBSTANCE STATUS CODE
844	1	2091	[COMSTAT22] COMPOSITION STATUS CODE
845	3	2092-2094	[RX22CAT1] MULTUM DRUG CATEGORY # 1
846	3	2095-2097	[RX22CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
847	3	2098-2100	[RX22CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
848	3	2101-2103	[RX22CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
849	3	2104-2106	[RX22V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
850	3	2107-2109	[RX22V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
851	3	2110-2112	[RX22V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
852	3	2113-2115	[RX22V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
853	3	2116-2118	[RX22V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
854	3	2119-2121	[RX22V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
855	3	2122-2124	[RX22V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
856	3	2125-2127	[RX22V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
857	3	2128-2130	[RX22V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
858	3	2131-2133	[RX22V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
859	3	2134-2136	[RX22V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
860	3	2137-2139	[RX22V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #23
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
861	6	2140-2145	[DRUGID23] DRUG ID
862	1	2146	[PRESCR23] PRESCRIPTION STATUS CODE
863	1	2147	[CONTSUB23] CONTROLLED SUBSTANCE STATUS CODE
864	1	2148	[COMSTAT23] COMPOSITION STATUS CODE
865	3	2149-2151	[RX23CAT1] MULTUM DRUG CATEGORY # 1
866	3	2152-2154	[RX23CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
867	3	2155-2157	[RX23CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
868	3	2158-2160	[RX23CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
869	3	2161-2163	[RX23V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
870	3	2164-2166	[RX23V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
871	3	2167-2169	[RX23V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
872	3	2170-2172	[RX23V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
873	3	2173-2175	[RX23V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
874	3	2176-2178	[RX23V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
875	3	2179-2181	[RX23V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
876	3	2182-2184	[RX23V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
877	3	2185-2187	[RX23V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
878	3	2188-2190	[RX23V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
879	3	2191-2193	[RX23V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
880	3	2194-2196	[RX23V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #24
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
881	6	2197-2202	[DRUGID24] DRUG ID
882	1	2203	[PRESCR24] PRESCRIPTION STATUS CODE
883	1	2204	[CONTSUB24] CONTROLLED SUBSTANCE STATUS CODE
884	1	2205	[COMSTAT24] COMPOSITION STATUS CODE
885	3	2206-2208	[RX24CAT1] MULTUM DRUG CATEGORY # 1
886	3	2209-2211	[RX24CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
887	3	2212-2214	[RX24CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
888	3	2215-2217	[RX24CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
889	3	2218-2220	[RX24V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
890	3	2221-2223	[RX24V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
891	3	2224-2226	[RX24V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
892	3	2227-2229	[RX24V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
893	3	2230-2232	[RX24V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
894	3	2233-2235	[RX24V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
895	3	2236-2238	[RX24V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
896	3	2239-2241	[RX24V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
897	3	2242-2244	[RX24V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
898	3	2245-2247	[RX24V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
899	3	2248-2250	[RX24V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
900	3	2251-2253	[RX24V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #25
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
901	6	2254-2259	[DRUGID25] DRUG ID
902	1	2260	[PRESCR25] PRESCRIPTION STATUS CODE
903	1	2261	[CONTSUB25] CONTROLLED SUBSTANCE STATUS CODE
904	1	2262	[COMSTAT25] COMPOSITION STATUS CODE
905	3	2263-2265	[RX25CAT1] MULTUM DRUG CATEGORY # 1
906	3	2266-2268	[RX25CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
907	3	2269-2271	[RX25CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
908	3	2272-2274	[RX25CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
909	3	2275-2277	[RX25V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
910	3	2278-2280	[RX25V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
911	3	2281-2283	[RX25V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
912	3	2284-2286	[RX25V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
913	3	2287-2289	[RX25V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
914	3	2290-2292	[RX25V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
915	3	2293-2295	[RX25V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
916	3	2296-2298	[RX25V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
917	3	2299-2301	[RX25V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
918	3	2302-2304	[RX25V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
919	3	2305-2307	[RX25V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
920	3	2308-2310	[RX25V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #26
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
921	6	2311-2316	[DRUGID26] DRUG ID
922	1	2317	[PRESCR26] PRESCRIPTION STATUS CODE
923	1	2318	[CONTSUB26] CONTROLLED SUBSTANCE STATUS CODE
924	1	2319	[COMSTAT26] COMPOSITION STATUS CODE
925	3	2320-2322	[RX26CAT1] MULTUM DRUG CATEGORY # 1
926	3	2323-2325	[RX26CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
927	3	2326-2328	[RX26CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
928	3	2329-2331	[RX26CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
929	3	2332-2334	[RX26V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
930	3	2335-2337	[RX26V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
931	3	2338-2340	[RX26V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
932	3	2341-2343	[RX26V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
933	3	2344-2346	[RX26V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
934	3	2347-2349	[RX26V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
935	3	2350-2352	[RX26V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
936	3	2353-2355	[RX26V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
937	3	2356-2358	[RX26V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
938	3	2359-2361	[RX26V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
939	3	2362-2364	[RX26V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
940	3	2365-2367	[RX26V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #27
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
941	6	2368-2373	[DRUGID27] DRUG ID
942	1	2374	[PRESCR27] PRESCRIPTION STATUS CODE
943	1	2375	[CONTSUB27] CONTROLLED SUBSTANCE STATUS CODE
944	1	2376	[COMSTAT27] COMPOSITION STATUS CODE
945	3	2377-2379	[RX27CAT1] MULTUM DRUG CATEGORY # 1
946	3	2380-2382	[RX27CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
947	3	2383-2385	[RX27CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
948	3	2386-2388	[RX27CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
949	3	2389-2391	[RX27V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
950	3	2392-2394	[RX27V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
951	3	2395-2397	[RX27V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
952	3	2398-2400	[RX27V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
953	3	2401-2403	[RX27V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
954	3	2404-2406	[RX27V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
955	3	2407-2409	[RX27V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
956	3	2410-2412	[RX27V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
957	3	2413-2415	[RX27V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
958	3	2416-2418	[RX27V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
959	3	2419-2421	[RX27V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
960	3	2422-2424	[RX27V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #28
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
961	6	2425-2430	[DRUGID28] DRUG ID
962	1	2431	[PRESCR28] PRESCRIPTION STATUS CODE
963	1	2432	[CONTSUB28] CONTROLLED SUBSTANCE STATUS CODE
964	1	2433	[COMSTAT28] COMPOSITION STATUS CODE
965	3	2434-2436	[RX28CAT1] MULTUM DRUG CATEGORY # 1
966	3	2437-2439	[RX28CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
967	3	2440-2442	[RX28CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
968	3	2443-2445	[RX28CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
969	3	2446-2448	[RX28V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
970	3	2449-2451	[RX28V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
971	3	2452-2454	[RX28V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
972	3	2455-2457	[RX28V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
973	3	2458-2460	[RX28V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
974	3	2461-2463	[RX28V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
975	3	2464-2466	[RX28V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
976	3	2467-2469	[RX28V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
977	3	2470-2472	[RX28V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
978	3	2473-2475	[RX28V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
979	3	2476-2478	[RX28V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
980	3	2479-2481	[RX28V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #29
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
981	6	2482-2487	[DRUGID29] DRUG ID
982	1	2488	[PRESCR29] PRESCRIPTION STATUS CODE
983	1	2489	[CONTSUB29] CONTROLLED SUBSTANCE STATUS CODE
948	1	2490	[COMSTAT29] COMPOSITION STATUS CODE
985	3	2491-2493	[RX29CAT1] MULTUM DRUG CATEGORY # 1
986	3	2494-2496	[RX29CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
987	3	2497-2499	[RX29CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
988	3	2500-2502	[RX29CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
989	3	2503-2505	[RX29V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
990	3	2506-2508	[RX29V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
991	3	2509-2511	[RX29V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
992	3	2512-2514	[RX29V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
993	3	2515-2517	[RX29V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
994	3	2518-2520	[RX29V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
995	3	2521-2523	[RX29V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
996	3	2524-2526	[RX29V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
997	3	2527-2529	[RX29V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
998	3	2530-2532	[RX29V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
999	3	2533-2535	[RX29V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
1000	3	2536-2538	[RX29V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DRUG-RELATED INFO FOR MEDICATION #30
			Please see “DRUG-RELATED INFO FOR MEDICATION #1” (page 85) for coding information.
1001	6	2539-2544	[DRUGID30] DRUG ID
1002	1	2545	[PRESCR30] PRESCRIPTION STATUS CODE
1003	1	2546	[CONTSUB30] CONTROLLED SUBSTANCE STATUS CODE
1004	1	2547	[COMSTAT30] COMPOSITION STATUS CODE
1005	3	2548-2550	[RX30CAT1] MULTUM DRUG CATEGORY # 1
1006	3	2551-2553	[RX30CAT2] MULTUM DRUG CATEGORY # 2 See RX1CAT1.
1007	3	2554-2556	[RX30CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
1008	3	2557-2559	[RX30CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.
			DRUG CATEGORY LEVELS
1009	3	2560-2562	[RX30V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
1010	3	2563-2565	[RX30V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
1011	3	2566-2568	[RX30V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
1012	3	2569-2571	[RX30V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
1013	3	2572-2574	[RX30V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
1014	3	2575-2577	[RX30V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
1015	3	2578-2580	[RX30V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
1016	3	2581-2583	[RX30V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
1017	3	2584-2586	[RX30V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
1018	3	2587-2589	[RX30V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
1019	3	2590-2592	[RX30V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
1020	3	2593-2595	[RX30V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

NAMCS SAMPLE DESIGN VARIABLES

NAMCS sampling design variables (in masked format) were first added to the 2000 public use file, and data years from 1993-1999 were re-released to include them. These variables were for use with statistical software such as SUDAAN that takes into account the complex sampling design of the survey. However, for those running versions of SAS, Stata, SPSS and other software that assumes a single stage of sampling, the multi-stage design variables provided on the public use files could not be used without modification. Therefore, in 2002, two new variables, CSTRATM and CPSUM, were developed, that could be used in such programs instead of the multi-stage variables. In 2003, the decision was made to include on the public use file just these two variables and not the multi-stage design variables that appeared in the past.

Until such time as the older public use files may be re-released to include these variables, data users wishing to combine data from 2003 and later years with data from earlier years will find it necessary to create CSTRATM and CPSUM for the earlier files. A technical paper, *Using Ultimate Cluster Models with NAMCS and NHAMCS Public Use Files,* is available for downloading at the Ambulatory Health Care Data website: http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm. This paper gives instructions on how to configure data files prior to 2002 for variance estimation based on 1-stage sampling models, such as those used in SAS proc surveymeans, Stata, SPSS, and the SUDAAN with-replacement option, and how to handle instances of single-case strata in the data on the older files. Please also see the section on Relative Standard Errors in the current document for more information on these variables and how to use them. PSU is primary sampling unit.

In 2016, the NAMCS sampling design changed, as described in more detail on page 12. For consistency with previous years, the same names used in earlier years have been used for the sample design variables. For additional information on combining data across years with the old and new sample designs, please see p. 131.

1021	8	2596-2603	[CSTRATM] Masked clustered stratum marker 10116101-10416115
1022	6	2604-2609	[CPSUM] Sampled provider marker 100001-100677
1023	4	2610-2613	[YEAR] SURVEY YEAR 2016
1024	1	2614	[SETTYPE] SETTING TYPE This item is intended for use when combining data from NAMCS and NHAMCS. 1 = Physician office (NAMCS)
1025	12	2615-2626	[PATWT] PATIENT VISIT WEIGHT This variable has been produced as an unrounded integer since 2015, which will make estimates slightly more precise. It is for use in producing national, regional, and MSA-level estimates 3855.83291 – 421070.91066

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ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
1026	9	2627-2636	[PHYSWT] PHYSICIAN WEIGHT Physician weight enables data users to make physician-level estimates. See also “Description of the NAMCS,” Marginal Data, and Appendix I. 75.95887 – 1527.72234

B. PHYSICIAN SPECIALTY LIST

The 2016 NAMCS sampling design grouped physicians into 14 strata, or specialty groups, for sampling purposes. These groups were developed based on information from the American Medical Association. Below is a list of the AMA physician specialties that were eligible for selection within each of the sample strata.

GENERAL AND FAMILY PRACTICE (Primary Care)

AMF Adolescent Medicine (Family Practice)
AMI Adolescent Medicine (Internal Medicine)
EFM Emergency Medicine/Family Medicine
FMP Family Medicine/Preventive Medicine
FP Family Practice
FPG Geriatric Medicine (Family Practice)
GP General Practice
HPF Hospice & Palliative Medicine (Family Medicine)
IFP Internal Medicine/Family Practice
IMG Geriatric Medicine (Internal Medicine)
IPM Internal Medicine/Preventive Medicine

INTERNAL MEDICINE (Primary Care)

IM Internal Medicine

PEDIATRICS (Primary Care)

ADL Adolescent Medicine (Pediatrics)
MPD Internal Medicine/Pediatrics
PD Pediatrics
PSM Pediatric Sports Medicine

PEDIATRICS (Medical)

CAP Child Abuse Pediatrics
CCP Pediatric Critical Care Medicine
DBP Developmental - Behavioral Pediatrics
EMP Pediatrics - Emergency Medicine
HPP Hospice & Palliative Medicine (Pediatrics)
NDN Neurodevelopmental Disabilities (Psychiatry & Neurology)
NDP Neurodevelopmental Disabilities (Pediatrics)
NPM Neonatal-Perinatal Medicine
PDA Pediatric Allergy
PDC Pediatric Cardiology
PDE Pediatric Endocrinology
PDI Pediatric Infectious Diseases
PDP Pediatric Pulmonology
PDT Medical Toxicology (Pediatrics)
PEM Pediatric Emergency Medicine (Pediatrics)
PG Pediatric Gastroenterology
PHO Pediatric Hematology/Oncology
PMG Pediatrics - Medical Genetics

PEDIATRICS (Medical)

PN Pediatric Nephrology
PPR Pediatric Rheumatology
PTP Pediatric Transplant Hepatology

GENERAL SURGERY (Surgical)

GS General Surgery

OBSTETRICS AND GYNECOLOGY (Primary Care)

GYN Gynecology
OBG Obstetrics and Gynecology
OBS Obstetrics

OBSTETRICS AND GYNECOLOGY (Surgical)

FPR Female Pelvic Medicine and Reconstructive Surgery (Obstetrics & Gynecology)
GO Gynecological Oncology
HPO Hospice & Palliative Med (Obstetrics & Gynecology)
MFM Maternal & Fetal Medicine
OCC Critical Care Medicine (Obstetrics & Gynecology)
UPR Female Pelvic Medicine & Reconstructive Surgery (Urology)

ORTHOPEDIC SURGERY (Surgical)

HSO Hand Surgery
OAR Adult Reconstructive Orthopedics
OFA Foot and Ankle Orthopedics
OMO Musculoskeletal Oncology
OP Pediatric Orthopedics
ORS Orthopedic Surgery
OSM Sports Medicine (Orthopedic Surgery)
OSS Orthopedic Surgery of the Spine
OTR Orthopedic Trauma

CARDIOVASCULAR DISEASES (Medical)

CD Cardiovascular Diseases

DERMATOLOGY (Medical)

D Dermatology

UROLOGY (Surgical)

U Urology
UP Pediatric Urology

PSYCHIATRY (Medical)

ADP Addiction Psychiatry
CHP Child and Adolescent Psychiatry
CPP Pediatrics/Psychiatry/Child & Adolescent Psychiatry
NUP Neuropsychiatry
P Psychiatry
PFP Forensic Psychiatry
PYA Psychoanalysis
PYG Geriatric Psychiatry
PYM Psychosomatic Medicine

NEUROLOGY (Medical)

CHN Child Neurology
CN Clinical Neurophysiology
ENR Endovascular Surgical Neuroradiology (Neurology)
EPL Epilepsy
ESN Endovascular Surgical Neuroradiology
N Neurology
NRN Neurology/Diagnostic Radiology/Neuroradiology
VN Vascular Neurology

OPHTHALMOLOGY (Surgical)

OPH Ophthalmology
OPR Ophthalmic Plastic and Reconstructive Surgery
PO Pediatric Ophthalmology

OTOLARYNGOLOGY (Surgical)

NO Neurotology (Otolaryngology)
OTO Otolaryngology
PDO Pediatric Otolaryngology
PSO Plastic Surgery within the Head & Neck (Otolaryngology)
SMO Sleep Medicine (Otolaryngology)

ALL OTHER (Surgical)

AS Abdominal Surgery
ASO Advanced Surgical Oncology
CCS Surgical Critical Care (Surgery)
CFS Craniofacial Surgery

ALL OTHER (Surgical) (cont.)

CHS Congenital Cardiac Surgery (Thoracic Surgery)
CRS Colon & Rectal Surgery
CS Cosmetic Surgery
DS Dermatologic Surgery
ES Endovascular Surgical Neuroradiology (Neurological Surgery)
FPS Facial Plastic Surgery
HNS Head & Neck Surgery
HPS Hospice and Palliative Medicine (Surgery)
HS Hand Surgery
HSP Hand Surgery (Plastic Surgery)
HSS Hand Surgery (Surgery)
NS Neurological Surgery
NSP Pediatric Surgery (Neurology)
OMF Oral & Maxillofacial Surgery
PCS Pediatric Cardiothoracic Surgery
PDS Pediatric Surgery (Surgery)
PRD Procedural Dermatology
PS Plastic Surgery
PSH Plastic Surgery within the Head & Neck
PSP Plastic Surgery within the Head & Neck (Plastic Surgery)
SO Surgical Oncology
TRS Traumatic Surgery
TS Thoracic Surgery
TTS Transplant Surgery
VS Vascular Surgery

ALL OTHER (Medical)

A Allergy
ADM Addiction Medicine
AHF Advanced Heart Failure and Transplant Cardiology
AI Allergy and Immunology
ALI Clinical Laboratory Immunology (Allergy & Immunology)
AM Aerospace Medicine
BIN Brain Injury Medicine
CBG Clinical Biochemical Genetics
CCG Clinical Cytogenetics
CCM Critical Care Medicine (Internal medicine)
CG Clinical Genetics
CHD Adult Congenital Heart Disease (Internal Medicine)
CMG Clinical Molecular Genetics
DDL Clinical and Lab Derm Immunology
DIA Diabetes
EM Emergency Medicine
END Endocrinology, diabetes and metabolism
EP Epidemiology
ESM Sports Medicine (Emergency Medicine)
ETX Medical Toxicology (Emergency Medicine)

ALL OTHER (Medical) (cont.)

FPP Psychiatry/Family Practice
FSM Family Practice/Sports Medicine
GE Gastroenterology
GPM General Preventive Medicine
HEM Hematology (Internal medicine)
HEP Hepatology
HO Hematology/Oncology
HPE Hospice & Palliative Medicine (Emergency Medicine)
HPI Hospice & Palliative Medicine (Internal Medicine)
HPM Hospice & Palliative Medicine
HPN Hospice & Palliative Medicine (Psychiatry & Neurology)
HPR Hospice & Palliative Med (Physical Medicine)
IC Interventional Cardiology
ICE Clinical Cardiac Electrophysiology
ID Infectious Diseases
IEC Internal Medicine/Emergency Medicine/Critical Care Medicine
IG Immunology
ILI Clinical and Laboratory Immunology (Internal Medicine)
IMD Internal Medicine/Dermatology
ISM Internal Medicine - Sports Medicine
LM Legal Medicine
MDM Medical Management
MEM Internal Medicine/Emergency Medicine
MG Medical Genetic**s**MO – Medical Oncology
MBG Medical Biochemical Genetics
MDG Internal Medicine/Medical Genetics
MN Internal Medicine/Neurology
MP Internal Medicine/Psychiatry
MPM Internal Medicine/Physical Medicine and Rehabilitation
NC Nuclear Cardiology
NEP Nephrology
NMN Neuromuscular Medicine
NMP Neuromuscular Medicine (Physical Medicine & Rehabilitation)
NTR Nutrition
OM Occupational Medicine
OMM Osteopathic Manipulative Medicine
ON Medical Oncology
PA Clinical Pharmacology
PCC Pulmonary Critical Care Medicine
PDD Pediatric Dermatology
PDM Pediatrics/Dermatology

ALL OTHER (Medical) (cont.)

PE Pediatric Emergency Medicine (Emergency Medicine)
PHL Phlebology
PHM Pharmaceutical Medicine
PHP Public Health and General Preventive Medicine
PLI Clinical and Laboratory Immunology (Pediatrics)
PLM Palliative Medicine
PM Physical Medicine and Rehabilitation
PME Pain Management
PMM Pain Medicine
PMN Pain Medicine (Neurology)
PMP Pain Management (Physical Medicine and Rehabilitation)
PPM Pediatrics/Physical Medicine & Rehabilitation
PPN Pain Medicine (Psychiatry)
PRO Proctology
PRS Sports Medicine (Physical Medicine and Rehabilitation)
PTX Medical Toxicology (Preventive Medicine)
PUD Pulmonary Diseases
PYN Psychiatry (Neurology)
REN Reproductive Endocrinology
RHU Rheumatology
RPM Pediatric Rehabilitation Medicine
SCI Spinal Cord Injury Medicine
SME Sleep Medicine
SMI Sleep Medicine (Internal Medicine)
SMN Sleep Medicine (Psychiatry & Neurology)
SMP Sleep Medicine (Pediatrics)
THP Transplant Hepatology (Internal Medicine)
UCM Urgent Care Medicine
UM Underseas Medicine (Preventive Medicine)
UME Underseas Medicine (Emergency Medicine)
VM Vascular Medicine
OS Other Specialty
US Unspecified

C. AMA SPECIALTIES REGROUPED INTO PRIMARY CARE, SURGICAL, AND MEDICAL SPECIALTIES

Below is a list of the AMA physician specialties used to develop the 14 physician specialty sampling groups, regrouped into primary care, surgical, and medical specialties for analytic purposes (see SPECCAT variable on file layout).

PRIMARY CARE SPECIALTIES

ADL Adolescent Medicine (Pediatrics)
AMF Adolescent Medicine (Family Practice)
AMI Adolescent Medicine (Internal Medicine)
EFM Emergency Medicine/Family Medicine
FMP Family Medicine/Preventive Medicine
FP Family Practice
FPG Geriatric medicine (Family Practice)
GP General Practice
GYN Gynecology
HPF Hospice & Palliative Medicine (Family Medicine)
IFP Internal Medicine/Family Practice
IM Internal Medicine
IMG Geriatric Medicine (Internal Medicine)
IPM Internal Medicine/Preventive Medicine
MPD Internal Medicine/Pediatrics
OBG Obstetrics & Gynecology
OBS Obstetrics
PD Pediatrics
PSM Pediatric Sports Medicine

SURGICAL SPECIALTIES

AS Abdominal Surgery
ASO Advanced Surgical Oncology
CCS Surgical Critical Care (Surgery)
CFS Craniofacial Surgery
CHS Congenital Cardiac Surgery (Thoracic Surgery)
CRS Colon & Rectal Surgery
CS Cosmetic Surgery
DS Dermatologic Surgery
ES Endovascular Surgical Neuroradiology (Neurological Surgery)
FPR Female Pelvic Medicine and Reconstructive Surgery
FPS Facial Plastic Surgery
GO Gynecological Oncology
GS General Surgery
HNS Head & Neck Surgery
HPO Hospice & Palliative Medicine (Obstetrics & Gynecology
HPS Hospice and Palliative Medicine (Surgery)
HS Hand Surgery
HSO Hand Surgery (Orthopedics)

SURGICAL SPECIALTIES (cont.)

HSP Hand Surgery (Plastic Surgery)
HSS Hand Surgery (Surgery)
MFM Maternal & Fetal Medicine
NO Neurotology (Otolaryngology)
NS Neurological Surgery
NSP Pediatric Surgery (Neurology)
OAR Adult Reconstructive Orthopedics
OCC Critical Care Medicine (Obstetrics & Gynecology)
OFA Foot And Ankle, Orthopedics
OMF Oral and Maxillofacial Surgery
OMO Musculoskeletal Oncology
OP Pediatric Orthopedics
OPH Ophthalmology
OPR Ophthalmic Plastic and Reconstructive Surgery
ORS Orthopedic Surgery
OSM Sports Medicine (Orthopedic Surgery)
OSS Orthopedic Surgery Of The Spine
OTO Otolaryngology
OTR Orthopedic Trauma
PCS Pediatric Cardiothoracic Surgery
PDO Pediatric Otolaryngology
PDS Pediatric Surgery (Surgery)
PO Pediatric Ophthalmology
PRD Procedural Dermatology
PS Plastic Surgery
PSH Plastic Surgery Within the Head & Neck
PSO Plastic Surgery Within the Head & Neck (Otolaryngology)
PSP Plastic Surgery Withi the Nead & Neck (Plastic Surgery)
SMO Sleep Medicine (Otolaryngology)
SO Surgical Oncology
TRS Trauma Surgery
TS Thoracic Surgery
TTS Transplant Surgery
U Urology
UP Pediatric Urology
UPR Female Pelvic Medicine & Reconstructive Surgery (Urology)
VS Vascular Surgery

MEDICAL SPECIALTIES

A Allergy
ADM Addiction Medicine
ADP Addiction Psychiatry
AHF Advanced Heart Failure and Transplant Cardiology
AI Allergy & Immunology
ALI Clinical Laboratory Immunology (Allergy & Immunology)
AM Aerospace Medicine
BIN Brain Injury Medicine
CAP Child Abuse Pediatrics
CBG Clinical Biochemical Genetics
CCG Clinical Cytogenetics
CCM Critical Care Medicine (Internal Medicine)
CCP Pediatric Critical Care Medicine
CD Cardiovascular Disease
CG Clinical Genetics
CHD Adult Congenital Heart Disease (Internal Medicine)
CHN Child Neurology
CHP Child and Adolescent Psychiatry
CMG Clinical Molecular Genetics
CN Clinical Neurophysiology
CPP Pediatrics/Psychiatry/Child & Adolescent Psychiatry
D Dermatology
DBP Developmental - Behavioral Pediatrics
DDL Clinical And Lab Derm Immunology
DIA Diabetes
EM Emergency Medicine
EMP Pediatrics/Emergency Medicine
END Endocrinology, Diabetes and Metabolism
ENR Endovascular Surgical Neuroradiology (Neurology)
EP Epidemiology
EPL Epilepsy
ESM Sports Medicine (Emergency Medicine)
ESN Endovascular Surgical Neuroradiology
ETX Medical Toxicology (Emergency Medicine)
FPP Psychiatry/Family Practice
FSM Family Practice/Sports Medicine
GE Gastroenterology
GPM General Preventive Medicine
HEM Hematology (Internal Medicine)
HEP Hepatology
HO Hematology/Oncology
HPE Hospice & Palliative Medicine (Emergency Medicine)
HPI Hospice & Palliative Medicine (Internal Medicine)
HPM Hospice & Palliative Medicine

MEDICAL SPECIALTIES (cont.)

HPN Hospice & Palliative Medicine (Psychiatry & Neurology)
HPP Hospice & Palliative Medicine (Pediatrics)
HPR Hospice & Palliative Medicine (Physical Medicine)
IC Interventional Cardiology
ICE Clinical Cardiac Electrophysiology
ID Infectious Disease
IEC Internal Medicine/Emergency Medicine/ Critical Care Medicine
IG Immunology
ILI Clinical and Laboratory Immunology (Internal Medicine)
IMD Internal Medicine/Dermatology
ISM Internal Medicine - Sports Medicine
LM Legal Medicine
MBG Medical Biochemical Genetics
MDG Internal Medicine/Medical Genetics
MDM Medical Management
MEM Internal Medicine/Emergency Medicine
MG Medical Genetics
MN Internal Medicine/Neurology
MP Internal Medicine/Psychiatry
MPM Internal Medicine/Physical Medicine And Rehabilitation
N Neurology
NC Nuclear Cardiology
NDN Neurodevelopmental Disabilities (Psychiatry & Neurology)
NDP Neurodevelopmental Disabilities (Pediatrics)
NEP Nephrology
NMN Neuromuscular Medicine
NMP Neuromuscular Medicine (Physician Medicine and Rehabilitation)
NPM Neonatal Perinatal Medicine
NRN Neurology/Diagnostic Radiology/Neuroradiology
NTR Nutrition
NUP Neuropsychiatry
OM Occupational Medicine
OMM Osteopathic Manipulative Medicine
ON Medical Oncology
P Psychiatry
PA Clinical Pharmacology
PCC Pulmonary Critical Care Medicine
PDA Pediatric Allergy
PDC Pediatric Cardiology
PDD Pediatric Ddermatology
PDE Pediatric Endocrinology
PDI Pediatric Infectious Diseases

MEDICAL SPECIALTIES (cont.)

PDM Pediatrics/Dermatology
PDP Pediatric Pulmonology
PDT Medical Toxicology (Pediatrics)
PE Pediatric Emergency Medicine (Emergency Medicine)
PEM Pediatric Emergency Medicine (Pediatrics)
PFP Forensic Psychiatry
PG Pediatric Gastroenterology
PHL Phlebology
PHM Pharmaceutical Medicine
PHO Pediatric Hematology/Oncology
PHP Public Health and General Preventive Medicine
PLI Clinical and Laboratory Immunology (Pediatrics)
PLM Palliative Medicine
PM Physical Medicine & Rehabilitation
PME Pain Management
PMG Pediatrics - Medical Genetics
PMM Pain Medicine
PMN Pain Medicine (Neurology)
PMP Pain Management (Physical Medicine & Rehabilitation)
PN Pediatric Nephrology
PPM Pediatrics/Physical Medicine & Rehabilitation
PPN Pain Medicine (Psychiatry)
PPR Pediatric Rheumatology
PRO Proctology
PRS Sports Medicine (Physical Medicine & Rehabilitation)
PTP Pediatric Transplant Hepatology
PTX Medical Toxicology (Preventive Medicine)
PUD Pulmonary Disease
PYA Psychoanalysis
PYG Geriatric Psychiatry
PYM Psychosomatic Medicine
PYN Psychiatry/Neurology
REN Reproductive Endocrinology
RHU Rheumatology
RPM Pediatric Rehabilitation Medicine
SCI Spinal Cord Injury Medicine
SME Sleep Medicine
SMI Sleep Medicine (Internal Medicine)
SMN Sleep Medicine (Psychiatry & Neurology)
SMP Sleep Medicine (Pediatrics)
THP Transplant Hepatology (Internal Medicine)
UCM Urgent Care Medicine
UM Underseas Medicine (Preventive Medicine)

MEDICAL SPECIALTIES (cont.)

UME Underseas Medicine (Emergency Medicine)
VM Vascular Medicine
VN Vascular Neurology
OS Other Specialty
US Unspecified Specialty

III. MARGINAL DATA

A. PATIENT VISITS

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Patient age recode			
Total	13,165	883,725,126	100.000
Under 15 years	1,515	156,860,287	17.75
15-24 years	901	65,077,377	7.364
25-44 years	2,390	170,733,687	19.32
45-64 years	3,910	252,037,293	28.52
65-74 years	2,373	132,148,254	14.954
75 years and over	2,076	106,868,228	12.093
Patient sex			
Total	13,165	883,725,126	100.000
Female	7,397	512,191,793	57.958
Male	5,768	371,533,333	42.042
Patient ethnicity - imputed			
Total	13,165	883,725,126	100.000
1 - Hispanic or Latino	1,744	146,703,340	16.601
2 - Not Hispanic or Latino	11,421	737,021,785	83.999
Patient race – imputed			
Total	13,165	883,725,126	100.000
White	11,237	740,739,815	83.82
Black	1,268	93,410,310	10.57
Other	660	49,575,000	5.61

Type of payment (recoded from multiple sources using hierarchy)

Total	13,165	883,725,126	100.000
All sources of payment are blank	244	18,630,060	2.108
Unknown	547	28,500,833	3.225
Private insurance	6,248	451,933,750	51.14
Medicare	3,874	217,966,396	24.665
Medicaid, CHIP or other state-based program	1,538	124,776,150	14.119
Worker's compensation	88	5,306,126	0.6
Self-pay	453	27,172,140	3.075
No charge/Charity	39	1,177,308	0.133
Other	134	8,262,362	0.935

Has this patient been seen in your practice before?

Total	13,165	883,725,126	100.000
Yes, established patient	10,612	757,028,578	85.663
No, new patient	2,553	126,696,548	14.337

Major reason for this visit

Total	13,165	883,725,126	100.000
Blank	341	21,392,419	2.421
New problem (less than 3 mos. onset)	3,728	269,048,752	30.445
Chronic problem, routine	4,307	262,411,269	29.694
Chronic problem, flare-up	1,135	71,300,578	8.068
Pre-surgery	312	14,739,841	1.668
Post-surgery	985	41,007,981	4.64
Preventive care	2,357	203,824,285	23.064

Number of medications coded

Total	13,165	883,725,126	100.000
0	3,787	230,235,549	26.053
1	2,409	175,340,165	19.841
2	1,577	111,253,624	12.589
3	1,111	80,971,628	9.163
4	794	57,188,220	6.471
5	663	45,652,644	5.166
6	513	32,645,052	3.694
7	443	26,328,959	2.979
8	391	25,993,497	2.941
9	263	15,777,840	1.785
10	272	20,431,293	2.312
11	183	12,160,278	1.376
12	153	10,794,007	1.221
13	127	7,835,130	0.887
14	118	8,043,877	0.91
15	70	4,042,439	0.457
16	55	3,801,311	0.43
17	53	2,686,659	0.304
18	42	3,290,727	0.372
19	30	2,253,454	0.255
20	27	2,072,147	0.234
21	18	1,160,481	0.131
22	17	1,140,785	0.129
23	12	755,439	0.085
24	13	682,216	0.077
25	5	411,981	0.047
26	4	198,946	0.023
27	2	78,517	0.009
28	5	188,139	0.021
29	2	82,176	0.009
30	6	227,945	0.026

Physician specialty - 14 groups

Total	13,165	883,725,126	100.000
General/family practice	1,950	202,494,191	22.914
Internal medicine	697	81,700,850	9.245
Pediatrics	1,020	136,119,383	15.403
General surgery	517	15,685,367	1.775
Obstetrics and gynecology	923	73,198,150	8.283
Orthopedic surgery	659	30,114,009	3.408
Cardiovascular diseases	577	27,783,348	3.144
Dermatology	1,274	49,947,051	5.652
Urology	925	26,153,128	2.959
Psychiatry	497	29,993,124	3.394
Neurology	464	14,407,199	1.63
Ophthalmology	1,385	46,289,214	5.238
Otolaryngology	985	28,965,423	3.278
Other specialties	1,292	120,874,689	13.678

B. DRUG MENTIONS

CATEGORY	RECORDS	WEIGHTED MENTIONS	PERCENT
Patient age recode			
Total	43,631	2,935,894,499	100.000
Under 15 years	2,354	273,963,067	9.332
15-24 years	1,537	114,889,109	3.913
25-44 years	5,028	355,276,524	12.101
45-64 years	14,210	994,275,282	33.866
65-74 years	10,480	642,275,848	21.877
75 years and over	10,022	555,214,668	18.911
Patient sex			
Total	43,631	2,935,894,499	100.000
Female	24,636	1,691,913,080	57.629
Male	18,995	1,243,981,419	42.371
Physician specialty - 14 groups			
Total	43,631	2,935,894,499	100.000
General/family practice	9,085	917,746,381	31.26
Internal medicine	3,093	352,649,859	12.012
Pediatrics	2,038	268,165,739	9.134
General surgery	1,579	45,885,581	1.563
Obstetrics and gynecology	1,747	117,902,289	4.016
Orthopedic surgery	1,542	72,230,624	2.46
Cardiovascular diseases	2,958	141,743,502	4.828
Dermatology	3,435	127,734,927	4.351
Urology	3,451	92,541,963	3.152
Psychiatry	1,129	60,336,339	2.055
Neurology	1,670	49,480,320	1.685
Ophthalmology	4,798	168,882,760	5.752
Otolaryngology	2,609	62,977,820	2.145
Other specialties	4,497	457,616,397	15.587

NOTE: Drug mentions reflect all drugs (up to 30) reported per visit. “RECORDS” refers to the unweighted count of drug mentions on the file.

CATEGORY	RECORDS	WEIGHTED CATEGORY	PERCENT
Drug therapeutic categories (using level 1 codes)			
Total	47,218	3,166,870,517	100.000
Anti-infectives	2,457	169,626,252	5.356
Antineoplastics	441	27,738,121	0.876
Biologicals	15	801,396	0.025
Cardiovascular agents	7,186	464,174,220	14.657
Central nervous system agents	8,510	599,317,632	18.925
Coagulation modifiers	2,025	130,351,253	4.116
Gastrointestinal agents	2,477	171,743,356	5.423
Hormones/hormone modifiers	2,576	162,340,007	5.126
Miscellaneous agents	1,213	70,862,396	2.238
Genitourinary tract agents	481	27,321,183	0.863
Nutritional products	4,138	275,532,747	8.7
Respiratory agents	3,134	254,916,832	8.049
Topical agents	4,508	249,322,081	7.873
Plasma expanders	3	102,191	0.003
Alternative medicines	1,090	64,543,331	2.038
Psychotherapeutic agents	2,128	138,849,372	4.384
Immunological agents	849	95,486,693	3.015
Radiologic agents	11	1,038,340	0.033
Metabolic agents	3,849	256,141,655	8.088
Medical gases	37	3,284,895	0.104
Pharmaceutical aids	90	3,376,566	0.107

Therapeutic categories are based on Lexicon Plus®, a proprietary database of Cerner Multum, Inc. The Lexicon Plus is a comprehensive database of all prescription and some nonprescription drug products available in the U.S. drug market. For additional information on the Multum Lexicon Drug Database, please refer to the following Web site: https://www.cerner.com/cerner_multum/. In this table, total of therapeutic categories exceeds total number of drug mentions because up to 4 therapeutic categories can be assigned per drug. For more information on coding therapeutic categories in NAMCS, see page 32.

C. PHYSICIAN ESTIMATES

CATEGORY	RECORDS	WEIGHTED PHYSICIANS	PERCENT
Physician specialty - 14 groups			
Total	677	330,581	100.000
General/family practice	92	60,692	18.359
Internal medicine	38	32,534	9.842
Pediatrics	49	43,342	13.111
General surgery	28	10,241	3.098
Obstetrics and gynecology	45	25,920	7.841
Orthopedic surgery	37	12,707	3.844
Cardiovascular diseases	33	13,031	3.942
Dermatology	61	14,839	4.489
Urology	42	7,464	2.258
Psychiatry	38	22,679	6.86
Neurology	30	9,170	2.774
Ophthalmology	65	18,345	5.549
Otolaryngology	44	7,253	2.194
Other specialties	75	52,366	15.84
Type of specialty (Primary, Medical, Surgical)			
Total	677	330,581	100
Primary care specialty	214	156,406	47.312
Surgical care specialty	245	67,865	20.529
Medical care specialty	218	106,311	32.159
Type of practice (solo/nonsolo)			
Total	677	330,581	100.000
Unknown	2	841	0.254
Solo	253	116,483	35.236
Non-solo	422	213,257	64.510

APPENDIX I

A. STANDARD ERRORS AND VARIANCE ESTIMATION

The standard error is primarily a measure of the sampling variability that occurs by chance because only a sample is surveyed, rather than the entire universe. The relative standard error (RSE) of an estimate is obtained by dividing the standard error of the estimate by the estimate itself and is expressed as a percentage of the estimate.

In the past, NAMCS micro-data file documentation contained formulas for approximating relative standard errors based on generalized variance curves as well as tables showing lowest reliable estimates based on curve coefficients. This was provided as an alternative for data users who lacked analytic software to produce standard errors and other measures of sampling variability. However, it has long been recognized that such approximations are less accurate than those produced using a statistical software package that takes into account the complex sample designs of surveys. As more data users have obtained access to sophisticated computer software over time, and as recent efforts by NCHS research staff to refine the generalized variance curves did not yield significant improvements, the decision was made starting with 2011 NAMCS data to discontinue the provision of these approximate methods of variance estimation.

Using computer software like SUDAAN to produce standard errors will, in general, yield results that are more accurate than those produced using generalized variance curves. This is especially true for clustered variables like race, provider seen, or expected source of payment. However, standard errors produced with such software using masked design variables, while improving substantially over generalized variance curve results, will not always be as accurate as those produced using unmasked data. Data files containing unmasked variables are confidential and are only available through the NCHS Research Data Center.

Starting with the 2012 NAMCS, a new sampling methodology was employed that used a list sample rather than a clustered sample. The design variables reflect the new sampling methodology. Examples of SUDAAN, SAS, Stata, and SPSS statements which incorporate these new design variables for variance estimation purposes are presented below.

The following example is for use with the 2016 NAMCS public use file. It can also be used to approximate variances for visit estimates when 2016 NAMCS data are combined with data from the National Hospital Ambulatory Medical Care Survey, which still uses the pre-2012 NAMCS clustered PSU sample design, or with previous years of NAMCS data.

SUDAAN 1-stage WR (With-Replacement) Option

This code provides a with-replacement ultimate cluster (1-stage) estimate of standard errors for a cross-tabulation with a dataset called TEST.

```
PROC CROSSTAB DATA = TEST DESIGN=WR;
NEST CSTRATM CPSUM /MISSUNIT;
```

It is important to keep the following in mind when trying to combine or analyze data across years:

NAMCS public use files from 2003-2016 only include first-stage design variables in their masked form, CSTRATM and CPSUM, for use in WR design options. From 1993-2002, a full set of masked design variables was provided. The decision to switch to ultimate cluster variables was initially made because many popular software products could not make use of the full set of design variables. Instructions are

provided for public use file data users on the survey website regarding how to create CSTRATM and CPSUM for data years prior to 2002, in order to have a consistent set of design variables for analysis. See the technical paper, *Using Ultimate Cluster Models with NAMCS and NHAMCS Public Use Files*, for more information: http://www.cdc.gov/nchs/namcs.htm.

If software other than SUDAAN is used to approximate estimate variances, other statements will be required by that software. The variance variables required by that software are the same as those defined above for SUDAAN software.

SAS - PROC SURVEYMEANS

```
PROC SURVEYMEANS DATA=TEST;
CLUSTER CPSUM;
STRATA CSTRATM;
```

Stata - For use with ultimate cluster design option:

The pweight (PATWT), strata (CSTRATM), and PSU (CPSUM) are set with the svyset command as follows:

Stata 8:
```
svyset [pweight=patwt], psu(cpsum) strata(cstratm)
```

Stata 9 and later:
```
svyset cpsum [pweight=patwt], strata(cstratm)
```

SPSS

To obtain variance estimates which take the sample design into account, IBM SPSS Inc.'s Complex Samples module can be used. This description applies to version 24.0. From the main menu, first click on 'Analyze', then 'Complex Samples', then 'Prepare for Analysis'. The 'Analysis Preparation Wizard' can be used to set CSTRATM as the stratum variable, CPSUM as the cluster variable, and PATWT as the weighting variable. The WR design option may be chosen. This will create the PLAN FILE syntax, which should resemble the code below, where PLAN FILE reflects the location you have selected to store the file on your computer:

```
CSPLAN ANALYSIS
  /PLAN FILE='DIRECTORY\PLANNAME.CSAPLAN'
  /PLAN VARS ANALYSISWEIGHT=PATWT
  /PRINT PLAN
  /DESIGN STAGELABEL= 'ANY LABEL'  STRATA=CSTRATM  CLUSTER=CPSUM
  /ESTIMATOR TYPE=WR.
```

After creating the plan file, various analyses can be selected from the 'Complex Samples' menu. This is an example of a crosstabulation with options selected for counts, percents, and standard errors, with missing data (if any) included:

```
CSTABULATE
  /PLAN FILE='DIRECTORY\PLANNAME.CSAPLAN'
  /TABLES VARIABLES = AGER BY SEX
  /CELLS POPSIZE ROWPCT COLPCT
```

```
/STATISTICS SE COUNT
/MISSING SCOPE = TABLE CLASSMISSING = INCLUDE.
```

Results using IBM SPSS with the WR option were found to be the same as those obtained using SUDAAN Release 11.0.1 with the WR option.

IMPORTANT NOTE REGARDING PHYSICIAN-LEVEL ESTIMATES:

The examples above can be used when producing visit or drug estimates. For physician-level estimates, the statements are the same, but replace PATWT with PHYSWT.

The PHYSWT variable itself should only be used to make estimates at the physician level. For this reason, it is only placed on the first record for each physician on the public use file. When running purely physician-level analysis, it is recommended that only records with PHYSWT > 0 be selected; this will give the correct sample counts and will not affect estimation of variance. Weighted estimates will be correct either way. For RDC researchers, please be sure to specify if PHYSWT is required and how it will be used, so that files can be constructed properly.

In addition to generating estimates for physician characteristics at the physician level, the addition of PHYSWT also means that one can link visit data with physician data. For example, one could examine average time spent with physicians across physicians rather than simply across visits. This type of analysis is slightly complicated; a description along with sample SAS code is available at the Ambulatory Health Care Data website. For more information, contact the Ambulatory and Hospital Care Statistics Branch using the information on page 2.

B. 2016 NAMCS ELECTRONIC PATIENT RECORD FORM - INSTRUCTIONS AND DEFINITIONS

NOTE: In years prior to 2012, NAMCS data collection agents were provided with a manual containing the PRF Instructions. This was used to train physicians and/or medical staff in completing the questionnaires and in familiarizing the data collection agents with the survey instructions in cases where they abstracted the data directly from medical records. Starting in 2012 when a computer-assisted mode of data collection was used for the first time, data collection agents abstracted data from medical records for nearly all sampled visits and recorded them using an automated tool. This tool contained online help screens which could be accessed during data collection for most data items, replacing the paper manuals. What is shown below is a compilation of the various help screen texts taken from the automated instrument.

PATIENT INFORMATION

Ethnicity

Ethnicity refers to a person's national or cultural group.
There are two categories for ethnicity, "Hispanic or Latino" and "Not Hispanic or Latino".

Enter the appropriate category according to the information in the medical record.
If the patient's ethnicity is not known or not obvious, do not determine the patient's ethnicity from his/her last name.

Ethnicity	**Definition**
1 - Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.
2 - Not Hispanic or Latino	All other persons.

Race

Enter all appropriate categories based on the information in medical record.
If the patient's race is not known or not obvious, enter the categories which in your judgment is (are) most appropriate. Do not determine the patient's race from their last name.

Race	**Definition**
1-White	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.
2 – Black or African American	A person having origins in any of the black racial groups of Africa.
3 - Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia,

	Pakistan, the Philippine Islands, Thailand, and Vietnam.
4 – Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5 – American Indian or Alaska Native	A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Expected Source(s) of Payment For This Visit

Type of payment	**Definitions**
1-Private insurance	Charges paid in-full by a private insurer (e.g., Blue Cross/Blue Shield) or in-part (e.g., deductibles or copays from another plan) either directly to the (hospital/provider) or reimbursed to the patient. Include charges covered under a private insurance sponsored prepaid plan. Excludes Medicare Advantage Plans.
2-Medicare	Charges paid in-full by a Medicare plan or in-part (e.g., deductibles or copays from another plan) either directly to the (hospital/provider) or reimbursed to the patient. Include charges covered under a Medicare sponsored prepaid plan. Includes Medicare Advantage Plan which is a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.
3-Medicaid or CHIP or other state-based program	Charges paid in-full by a Medicaid plan or in-part (e.g., deductibles or copays from another plan) either directly to the (hospital/provider) or reimbursed to the patient. Include charges covered under a Medicaid sponsored prepaid plan (HMO), “managed Medicaid” or the Children’s Health Insurance Program (CHIP). PROGRAM NAMES FOR MEDICAID, CHIP, STATE-/LOCAL-SPONSORED, AND OTHER HEALTH INSURANCE PROGRAMS. Please find the state where the facility is located in the FR Manual. Note: Medicaid programs are often called “Medicaid,” “Medical Assistance Program,” or “Title 19." Children’s Health Insurance Programs are often called “CHIP,” “SCHIP,” or “Title XXI Program.” Many states have unique names for their health insurance programs. Those program names are listed by state.
4-Workers’ compensation	Includes programs designed to enable employees injured on the job to receive financial compensation regardless of fault.

5-Self-pay	Charges, to be paid by the patient or patient's family which will not be reimbursed by a third party. "Self- pay" includes visits for which the patient is expected to be ultimately responsible for most of the bill, even though the patient never actually pays it. DO NOT enter "Self-pay" for a copayment or deductible.
6-No charge/Charity	Visits for which no fee is charged (e.g., charity, special research, or teaching). Do not include visits paid for as part of a total package (e.g., prepaid plan visits, post- operative visits included in a surgical fee, and pregnancy visits included in a flat fee charged for the entire pregnancy). Enter the payment category or categories that indicate how the services were originally paid.
7-Other	Other sources of payment not covered by the above categories, such as TRICARE, state and local governments, private charitable organizations, and other liability insurance (e.g., automobile collision policy coverage).
8-Unknown	The expected source of payment is unknown.

Tobacco Use

Response	Description
1. Not current	Select if there is NO evidence in the chart that the patient is currently using tobacco*.
2. Current	Select if there is evidence in the chart that the patient is currently using tobacco*.
3. Unknown	Select if it is unclear whether or not the patient is currently using tobacco*.

***** Tobacco use is defined as smoking cigarettes/cigars, using snuff, or chewing tobacco.

Prior Tobacco Use

Response	Description
1. Never	Select if there is NO evidence in the chart that the patient has ever used tobacco* at some point during his/her lifetime.
2. Former	Select if there is evidence in the chart that the patient has used tobacco* at some point during his/her lifetime.
3. Unknown	Select if it is unclear whether or not the patient is a never or former tobacco* user.

***** Tobacco use is defined as smoking cigarettes/cigars, using snuff, or chewing tobacco.

BIOMETRICS/VITAL SIGNS

Enter the patient's height if measured at this visit in the appropriate field, i.e.,-(ft and/or/in or cm).
If it was not measured at this visit and the patient is 21 years of age or over, then review the chart (up to 1 year) for the last time that height was recorded and enter that value.

Enter the patient's weight if measured at this visit in the appropriate field (lb oz or kg or gm [grams]). Only collect weight at current visit and not during pregnancy.

Enter the patient's initial temperature if measured at this visit.
Enter the appropriate type of measurement (degrees C or F).

INJURY

Response	Description
1. Yes, injury/trauma	Select this if the visit involves an injury/trauma, i.e., physical damage to the body typically from the application of an external force. Types of physical injuries include: Bruises, cuts, lacerations, open wounds, amputations, sprains, strains, fractures (broken bones), dislocations, damage to internal organs, traumatic brain injury (TBI), concussion, damage to nerves or spinal cord, burns, hypothermia, near drowning, suffocation, foreign bodies, insect/animal bites, etc. Types of events that can result in injury include: motor vehicle crashes, transportation events, falls, striking against or being struck by a person or object as in sports, burns, drowning, suffocation, cuts and stabbings, overexertion, foreign bodies, being crushed by machinery, beaten with fists or objects, gunshot/pellet gun wounds, etc. Includes Visits involving: • New injuries. • Follow-up for previously treated injuries. • Flare-ups of problems due to old injuries. Excludes Visits involving: • Injuries caused by medical/surgical treatment or ingestion of a harmful substance. • Bodily harm from other external causes, such as infectious diseases, and internal causes, such as chronic diseases. • Psychological trauma, such as Post Traumatic Stress Disorder • Suicidal ideation with no physical injury • Complaint of pain without evidence of physical injury or an

	injury mechanism
2. Yes, overdose/ poisoning	Select this if the visit involves a poisoning, i.e., ingestion, inhalation, absorption through the skin or mucous membranes, or injection of a substance resulting in a harmful effect. Poisoning can result from both overdose from medications/drugs as well as exposure to toxic substances. Includes Visits involving ingestion/exposure to: • Overdose or misuse of prescription drugs, over-the-counter medications, vitamins, and illicit/street drugs • Household cleaners, bleach, soaps, detergents, solvents • Pesticides • Carbon monoxide • Alcohol containing products (ethanol, ethyl alcohol, methanol) except situations described in the “excludes” category • Nonpharmaceutical inhalants • Alcohol-based topical agent used for medicinal purposes. • Poisonous mushrooms, berries Excludes Visits involving: • Harmful effects from bacterial illnesses (such as “food poisoning”) • Drunkenness • Alcohol withdrawal • Drug withdrawal • Drug dependency • Medical conditions such as liver failure, pancreatitis, or renal failure resulting from past drug or alcohol abuse • Referrals for detox or medical clearance • Allergic reaction to a drug • Dermatitis from contact with poison ivy, poison oak, etc.
3. Yes, adverse effect of medical/surgical treatment or adverse effect of medicinal drug	Select this if the visit involves an adverse effect of medical treatment, i.e., a reaction to the patient’s own prescription or over-the-counter medication or dietary supplement taken according to directions, the label, or as prescribed. Unintended and undesired effects include: adverse drug reactions, allergic drug reactions, side effects, drug-drug interactions, drug-alcohol interactions. Also select this if visit involves an adverse effect of surgical treatment, i.e., bodily harm directly caused by surgical care or the placement of a medical product/device in a patient. Examples include pneumothorax from central venous catheter placement, postoperative wound infection, a foreign object left in the body after a procedure, etc. Includes • An adverse effect that occurred after use of one’s own

	prescribed or over-the-counter medication/ supplement taken as prescribed or directed. • Surgical care provided in error or according to standards of practice, but resulting in bodily harm to the patient. • Presenting complaints/diagnoses may include keywords such as: “adverse,” “allergic,” “side effects,” “caused by or induced by,” “reaction to” or “secondary to.” Excludes Visits involving: • Illegal drugs. • Patients EXCEEDING the prescribed or recommended dose of prescription drugs, OTC medications, or dietary supplements. • Patients who took LESS than the prescribed or recommended dose. • Patients who took prescribed medication belonging to someone else. • Patients with an allergic reaction to a food or insect bite.
4. No	Select this if visit is not related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment.
5. Unknown	Select if it is unclear from the documentation whether or not this visit is related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment or adverse effect of medicinal drug.
Injury within 72 hours	**Definitions**
1-Yes	Select this response if the injury/trauma or overdose/poisoning occurred within 72 hours prior to this visit. Use either of these methods to verify timing: • If the date/time of the injury/trauma or overdose/poisoning is documented in the medical record, then use that information to calculate if the event occurred within 72 hours. • If the date/time of the injury/trauma or overdose/poisoning is not specifically provided, look for other text that might describe if the event occurred within 72 hours (e.g., “this morning,” “last night”, “two days ago”).
2-No	Select this response if the injury/trauma or overdose/poisoning occurred more than 72 hours prior to this visit. Use any of the following methods to verify timing: • If the date/time of the injury/trauma or overdose/poisoning is documented in the medical record, then use that information to calculate if the event occurred more than

	72 hours. • If the date/time of the injury/trauma or overdose/poisoning is not specifically provided, look for other text that might describe if the event occurred more than 72 hours (e.g., "two weeks ago," "since childhood", "a long time ago"). • If it's clear that the visit is for flare-up or problems due to an old injury, select "No". • If the date and time of the injury/trauma or overdose/poisoning is not provided and it is documented in the medical record that this is a follow-up visit (e.g., for suture removal, for removal of a cast, for follow-up), then select "No".
3-Unknown	Select this response if there is no date/time or text that indicates when the injury/trauma or overdose/poisoning might have occurred.
4-Not applicable	Select this response if the visit does not involve an injury/trauma or overdose/poisoning.

Intentional injury	**Definitions**
1-Suicide attempt with intent to die	The injury/trauma or overdose/poisoning is the result of a self-directed act carried out on purpose in which there is intent to harm oneself to the point of death. Both fatal and non-fatal outcomes from suicide attempts are included in this category.
2-Intentional self-harm without intent to die	The injury/trauma or overdose/poisoning is the result of self-directed behavior in which there is **intent to harm oneself, but no documented intent to kill oneself**. Include instances where the medical record • Clearly states that the patient intended to harm him/herself; **AND** • Clearly states that the patient did not intend to kill him/herself. Both fatal and non-fatal outcomes from intentional self-harm are included in this category.
3-Unclear if suicide attempt or intentional self-harm without intent to die	It is unclear whether the self-directed injury/trauma or overdose/poisoning is a suicide attempt or intentional self-harm without intent to die.
4-Intentional harm inflicted by another person (e.g., assault, poisoning)	The injury/trauma or overdose/poisoning resulted from an act carried out on purpose by one or more persons with the intent of causing harm, injury, or death to another person. This category includes harm to both intended as well as unintended victims of violent acts (e.g., innocent bystanders). This category excludes unintentional shooting victims (other than those occurring during an act of violence), unintentional drug overdoses, and children or teenagers "horsing" around.
5-Intent unclear	The medical record clearly states that there is difficulty in determining whether the event was intentional or accidental. Examples include drug poisoning events where it is unclear whether the overdose was accidental or a suicide attempt, or injuries to children or adults where it is unclear whether the injury was accidental or due to child abuse or domestic

	violence or elder abuse. Select this response only if there are statements in the medical record that question whether the event was intentional or accidental.

Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment

Provide a brief description of **who**, **what**, **when**, **where**, and **why** associated with the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment including adverse effects of a medicinal drug (e.g., allergy to penicillin).

For reasons of confidentiality, do not include proper names or dates in the description.

Indicate the place of the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment (e.g., residence, recreation or sports area, street or highway, school, hospital, public building, or industrial place). Include any post-surgical complications and if it involved an implant, specify what kind. If safety precautions were taken, describe them (e.g., seat belt use).

Be sure to include the mechanism that caused the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment (e.g., farm equipment, fire, arsenic, knife, pellet gun). If it was a work-related injury or poisoning, specify the industry of the patient's employment (e.g., food service, agricultural, mining, health services, etc.).

Describe in detail the circumstances that caused the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment (e.g., fell off monkey bars, motor vehicle collision with another car, spouse beaten with fists by spouse). Include information on the role of the patient associated with the injury (e.g., bicyclist, pedestrian, unrestrained driver or passenger in a motor vehicle, horseback rider), the specific place of occurrence (e.g., lake, school football field), and the activity in which the patient was engaged at the time of the injury (e.g., swimming, boating, playing football).

Also include what happened to the patient and identify the mechanism that was immediately responsible for the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment. In addition, record the underlying or precipitating cause (i.e., the event or external cause of injury that initiated and led to the mechanism of injury). An example is a house fire that caused a person to jump out of the window. Both the precipitating or underlying cause (house fire) and the mechanism (fall from roof) would be important to record.

It is especially important to record as much detail about falls and motor vehicle crashes as possible.

For falls, indicate what the fall was from (e.g., steps) and where the patient landed (e.g., pavement).

For motor vehicle crash, indicate if it occurred on a street or highway versus a driveway or parking lot.

The National Center for Health Statistics will use the information collected to classify the cause of the injury using the International Classification of Diseases, Supplementary Classification of External Causes of Injury and Poisoning codes (ICD-9-CM E-Codes).

REASON FOR VISIT

List the first 5 reasons for visit (i.e., complaint(s), symptom(s), problem(s), concern(s) of the patient) in the order in which they appear. Start with the Chief Complaint which should be entered in (1). Move on to the Patient History section of the chart and enter up to four additional reasons for the visit in (2), (3), (4) and

(5). It is not necessary to record more than five. Enter 0 for None/No more.

By “most important” we mean the problem or symptom which in the physician’s judgment was most responsible for the patient making this visit.

This is one of the most important items on the Patient Record form. No similar data on ambulatory visits are available in any other survey and there is great interest in the findings. Please be mindful of the following points:

- In this item, NCHS is interested in how the patient defines the reason for the visit (e.g., "cramps after eating," or "fell and twisted my ankle") or the Chief Complaint. However, when taking the Patient History, the provider may probe and elicit other complaints or reasons for the visit. These should be entered in lines (2)-(5).

- Conceivably, the patient may be undergoing a course of treatment for a serious illness, but if his/her most important reason for this visit is a sore throat or a cut finger, then that is the reason that should be entered.

- There will be visits by patients for reasons other than some complaint or symptom. Examples might be well baby check-up or routine prenatal care. In such cases, simply record the reason for the visit.

Reminder: If the reason for a patient's visit is to pay a bill, have an insurance form completed, or drop off a specimen, then this patient’s visit is not eligible for the sample and a Patient Record form should not be completed.

Major reason for this visit

Problem	Definitions
1-New problem (< 3 mos onset)	A visit for a condition, illness, or injury having a relatively sudden or recent onset (within 3 months of this visit).
2-Chronic problem, routine	A visit primarily to receive care or examination for a preexisting chronic condition, illness, or injury (onset of condition was 3 months or more before this visit).
3-Chronic problem, flare- up	A visit primarily due to a sudden exacerbation of a pre-existing chronic condition.
4-Pre-surgery	A visit scheduled primarily for care required prior to surgery/procedure (e.g., pre-surgery tests).
5-Post-surgery	A visit scheduled primarily for care required following surgery/procedure (e.g., removing sutures).
6-Preventive care (e.g., routine, prenatal well-baby screening, insurance, general exams)	General medical examinations and routine periodic examinations. Includes prenatal care, annual physicals, well-child exams, screening, and insurance examinations.

CONTINUITY OF CARE

Are you the patient's primary care provider?

The primary care provider plans and provides the comprehensive primary health care of the patient. Enter "Yes" if the health care provided to the patient during this visit was from his/her primary care provider. If the provider seen at this visit was substituting for the primary care provider, also enter "Yes." Enter "No" if care was not from the primary care provider or "Unknown" if it is not known.

Was patient referred for this visit?

If "No" or "Unknown" is checked, also indicate whether the patient was referred for this visit by another health care provider. This item provides an idea of the "flow" of ambulatory patients from one provider to another. Enter "Yes", "No" or "Unknown" category, as appropriate. Notice that this item concerns referrals to the sample physician/CHC provider by a different physician/CHC provider. The interest is in referrals for this visit and not in referrals for any prior visit.

Referrals are any visits that are made because of the advice or direction of a physician/CHC provider other than the physician/CHC provider being visited.

Has the patient been seen in this practice before?

"Seen" means "provided care for" at any time in the past. Enter "Yes, established patient" if the patient was seen before by any provider in the clinic. Exclude this visit.

Enter "No, new patient" if the patient has not been seen in the clinic before. If "Yes" is checked, also indicate approximately how many past visits the patient has made to this clinic within the last 12 months. Do not include the current visit in your total. If you cannot determine how many past visits were made, then enter "unknown". Include all visits to other providers in this clinic.

How many past visits to this practice in the last 12 months?

Indicate approximately how many past visits the patient has made to this office/CHC/clinic within the last 12 months. Include all visits to other providers in this office/CHC/clinic.

Do not include the current visit in the total.

If you cannot determine how many past visits were made, then select the "Unknown" box.

DIAGNOSIS

(1)Primary diagnosis
(2)Other
(3)Other
(4)Other
(5)Other

This is one of the most important items on the Patient Record form. The primary diagnosis-refers to the

provider's primary diagnosis for this visit. If possible, enter a final or provisional diagnosis, otherwise, use "problem" terms. Do not enter "rule out" diagnosis. If the patient was not seen by a physician, then the diagnosis by the main health care provider should be recorded.

If a patient appears for postoperative care (follow-up visit after surgery), record the postoperative diagnosis as well as any other. The postoperative diagnosis should be indicated with the letters "P.O." Do not enter the operative procedure.

(2), (3), (4), (5), Other:
Enter up to four diagnoses which existed at the time of the visit if they are of DIRECT CONCERN to the visit. Include chronic disease.

Regardless of the diagnoses previously entered, does the patient now have:

Condition	**Description**
1. Alcohol misuse, abuse or dependence	Select box if 1) any of these terms are used; or 2) if terms such as alcoholism, excessive alcohol use, heavy, problem drinking, binge, or chronic drinking/drinker are stated. 'Alcohol' may be abbreviated as 'EtOH.'
2. Alzheimer's disease/Dementia	Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. Alzheimer's disease is an irreversible, progressive brain disease that slowly destroys memory and thinking skills, and eventually even the ability to carry out the simplest tasks. It is the most common cause of dementia among older people.
3. Arthritis	Arthritis includes those types of rheumatic diseases in which there is an inflammation involving joints, (e.g., osteoarthritis, rheumatoid arthritis, acute arthritis, juvenile chronic arthritis, hypertrophic arthritis, Lyme arthritis, and psoriatic arthritis).
4. Asthma	Asthma is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow, obstruction, and bronchospasm. It includes extrinsic, intrinsic, and chronic obstructive asthma.
5. Autism spectrum disorder	Autism spectrum disorder includes autism, autistic disorder, Asperger's disorder, childhood disintegrative disorder, or the catch-all diagnosis of pervasive developmental disorder not otherwise specified.
6. Cancer	Cancer includes any type of cancer (ca), such as carcinoma, sarcoma, leukemia, and lymphoma. Do not include a history of cancer that is in remission or has been cured.
7. Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)	Cerebrovascular disease/History of stroke or transient ischemic attack (TIA) is a group of brain dysfunctions related to disease of the blood vessels supplying the brain. Hypertension is the most important cause. The results of cerebrovascular disease can include a stroke, or occasionally a hemorrhagic stroke. A transient ischemic attack is a brief

	episode in which the brain gets an insufficient blood supply. Include a history of stroke or TIA.
8. Chronic kidney disease (CKD)	Chronic kidney disease (CKD) includes conditions that damage the kidneys and decrease their ability to remove wastes that can build to high levels in the blood. Chronic kidney disease may be caused by diabetes, high blood pressure and other disorders.
9. Chronic obstructive pulmonary disease (COPD)	Chronic obstructive pulmonary disease (COPD) includes chronic bronchitis and emphysema, but excludes asthma.
10. Congestive heart failure (CHF)	Congestive heart failure (CHF) is generally defined as the inability of the heart to supply sufficient blood flow to meet the needs of the body. Does not include aystole or cardiac arrest.
11. Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)	Coronary artery disease (CAD), also known as ischemic heart disease (IHD), occurs when the arteries that supply blood to heart muscle become hardened and narrowed. This is due to the buildup of cholesterol and other material, called plaque, on their inner walls. This buildup is also referred to as atherosclerosis. Only include ”history of myocardial infarction” if the patient had a heart attack or myocardial infarction (MI) prior to the sampled visit. A heart attack or MI occurs when the blood vessels that supply blood to the heart are blocked, preventing enough oxygen from getting to the heart. The heart muscle dies or becomes permanently damaged. Also known as acute myocardial infarction (AMI).
12. Depression	Depression includes affective disorders and major depressive disorders, such as episodes of depressive reaction, psychogenic depression, and reactive depression.
13. Diabetes mellitus (DM), Type 1	Type 1 diabetes mellitus is also known as insulin-dependent or IDDM. Excludes diabetes insipidus and gestational diabetes.
14. Diabetes mellitus (DM), Type 2	Type 2 diabetes mellitus is also known as non-insulin dependent or NIDDM. Excludes diabetes insipidus and gestational diabetes.
15. Diabetes mellitus (DM), Type unspecified	Excludes diabetes insipidus and gestational diabetes.
16. End-stage renal disease (ESRD)	Includes end-stage renal disease (ESRD) and chronic kidney failure due to diabetes or hypertension. May be abbreviated as “ESRD.”
17. History of pulmonary embolism (PE) or deep vein thrombosis (DVT)	Only include if the patient had a pulmonary embolism (PE) or a diagnosis of deep vein thrombosis (DVT) or venous thromboembolism (VTE) prior to the sampled visit. Pulmonary

	embolism (PE) is a blockage of the main artery of the lung or one of its branches by a substance that has travelled from elsewhere in the body through the bloodstream (embolism). Usually this is due to embolism of a thrombus (blood clot) from the deep veins in the legs, a process termed venous thromboembolism (VTE). Deep vein thrombosis (DVT) (also known as deep venous thrombosis) is the formation of a blood clot ("thrombus") in a deep vein. It is a form of thrombophlebitis (inflammation of a vein with clot formation). DVT commonly affects the leg veins (such as the femoral vein or the popliteal vein) or the deep veins of the pelvis.
18. HIV Infection/AIDS	HIV infection is a condition caused by the human immunodeficiency virus (HIV) which gradually destroys the immune system and makes it harder for the body to fight infections. Asymptomatic (without symptoms) HIV infection is a phase of chronic infection with HIV during which there are no symptoms of HIV infection. AIDS (acquired immune deficiency syndrome) is the final stage of HIV disease, which causes severe damage to the immune system.
19. Hyperlipidemia	Hyperlipidemia is the condition of abnormally elevated levels of any or all lipids and/or lipoproteins in the blood. Also known as hypercholesterolemia.
20. Hypertension	Hypertension or high blood pressure is a cardiac chronic medical condition in which the systemic arterial blood pressure is elevated. It is the opposite of hypotension. Hypertension is classified as either primary (essential) hypertension or secondary hypertension. “Primary hypertension” means high blood pressure with no obvious medical cause. “Secondary hypertension” is caused by other conditions that affect he kidneys, arteries, heart or endocrine system. Include both primary and secondary hypertension.
21. Obesity	Obesity is a term used to describe body weight that is much greater than what is healthy. Adults with a body mass index (BMI, calculated as weight in kilograms divided by height in meters squared) greater than or equal to 30 kg/m2 are considered obese. Any patient who is more than 100 pounds overweight or who has a BMI greater than or equal to 40 kg/m2 is considered morbidly obese.
22. Obstructive sleep apnea (OSA)	Select box if obstructive sleep apnea (OSA), sleep apnea, or complex/mixed sleep apnea is stated. Do not select if central sleep apnea (CSA) is stated.
23. Osteoporosis	Osteoporosis refers to the thinning of bone tissue and loss of bone density over time. This reduction in the amount of bone mass leads to fractures after minimal trauma.
24. Substance abuse or dependence	Select box if 1) any of these terms are used; 2) if terms implying a chronic condition such as addiction, addict, illicit drug use, or injection/intravenous drug use/user

	(IDU/IVDU/IVDA) are stated; 3) if terms implying an episode of abuse/misuse are stated, such as “drugged/stones/high”; or 4) if specific drug use is stated (e.g., cocaine use, opioid dependence), not including tobacco/nicotine or alcohol.
25. None of the above	Enter “None of the above” if none of the conditions listed above exist.

SERVICES

Enter all services that were ordered or provided during this visit for the purpose of screening (i.e., early detection of health problems in asymptomatic individuals) or diagnosis (i.e., identification of health problems causing individuals to be symptomatic).

EACH SERVICE ORDERED OR PROVIDED SHOULD BE ENTERED.

At visits for a complete physical exam, several tests may be ordered prior to the visit, so that the results can be reviewed during the visit. Since these services are related to the visit, appropriate items should be entered.

Enter “NO SERVICES” if no examinations/screenings, laboratory tests, imaging, treatments, health education/counseling, or other services not listed were ordered or provided.

Services	**Definitions**
1. NO SERVICES	Select box if no examinations/screenings, laboratory tests, imaging, procedures, treatments, health education/counseling or other services were ordered or provided at this visit.
Examinations/Screenings:	
2- Alcohol abuse screening (includes AUDIT, MAST, CAGE, T-ACE)	Select box if alcohol abuse screening was documented. Screening might also be documented by noting the names questionnaires such as: AUDIT, MAST, CAGE, and T-ACE. Select box if 1) any of these terms are used; or 2) if AUDIT-C or CAGE-AID is stated. CAGE-AID screens for alcohol and substance use. ‘Alcohol’ may be abbreviated as ‘EtOH.’
3-Breast	A clinical breast exam (CBE) is a physical examination of the breast.
4-Depression screening	Depression screening is the assessment of whether the patient has signs or symptoms of depression and may involve the administration of a standard questionnaire to assess whether a patient is experiencing symptoms of depression.

5-Domestic violence screening	Select box if intimate partner violence (IPV) is listed. IPV screening tools include: Hurt, Insult, Threaten, and Scream (HITS); Woman Abuse Screening Tool (WAST); Partner Violence Screen (PVS); and Abuse Assessment Screen (AAS).
6-Foot	A foot exam includes visual inspection, sensory exam, and pulse exam.
7-Neurologic	A neurologic exam involves an assessment of, movement and coordination, reflexes, vision, balance, and sensation, and cognitive ability. It typically involves a series of simple questions and physical assessments that provide information about the nervous system. It is divided into several components, each focusing on a different part of the nervous system: mental status; cranial nerves; motor system; sensory system; deep tendon reflexes (DTRs); coordination and the cerebellum; and gait.
8-Pelvic	A pelvic exam is an internal examination of the female reproductive organs.
9-Rectal	A digital (finger) rectal examination (DRE) is used to examine the anus and rectum. In men, it is also used to check the prostate gland. In women, it is also used to check the uterus and ovaries. It might be documented as rectal exam, DRE or RV (rectovaginal exam performed with a pelvic examination).
10-Retinal/Eye	A retinal exam includes any of the following: ophthalmoscopy, funduscopy, and dilated retinal exam (DRE). An eye exam includes any of the following: ophthalmoscopy, funduscopy, slit lamp exam, visual field (VF) exam, and visual acuity exam (vision test). Ophthalmoscopy (funduscopy or fundoscopy) is a test that allows a health professional to see inside the fundus of the eye (interior surface of the eye, opposite the lens, and includes the retina, optic disc, and macula) and other structures using an ophthalmoscope (or funduscope). It is done as part of an eye exam and may be done as part of a routine physical exam. A slit lamp exam uses an instrument that provides a magnified, three-dimensional (3-D) view of different parts of the eye.
11-Skin	A skin exam is a physical exam used to identify skin problems, such as skin cancer, including suspicious growths, moles or lesions.
12- Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)	NIDA/NM ASSIST, CAGE-AID and DAST-10 are names of screening questionnaires. NM ASSIST and CAGE-AID screen for alcohol and substance use. Select box if screening ordered or performed 1) around substance use/abuse; illicit drug use, or injection/intravenous drug use (IDU/IVDU/IVDA); or 2) around use of a specific substance (e.g., cocaine use, opioid dependence), not including tobacco/nicotine or alcohol.

Laboratory tests:	
13-Basic metabolic panel (BMP)	A basic metabolic panel includes kidney tests (BUN/creatinine), electrolytes (sodium, potassium, bicarbonate, and chloride) and glucose. Examples of documentation of a basic metabolic panel (BMP) include SMA-7, Chem-1, and CPBASIC.
14-CBC	A complete blood count includes white blood cell count (WBC), red blood cell count (RBC), hemoglobin, hematocrit, platelet, mean corpuscular volume (MCV), mean corpuscular hemoglobin (MCH), and red cell distribution width (RDW). Might be abbreviated as ABC (automated blood count).
15-Chlamydia test	Chlamydia tests use a sample of body fluid or urine to see whether chlamydia bacteria (*Chlamydia trachomatis*) are present and causing an infection. Chlamydia tests may be abbreviated as CT.
16-Comprehensive metabolic panel (CMP)	Examples of documentation of a CMP include SMA-18 or 20, Chem-20, CPCOMP. A CMP includes the 7 basic metabolic panel (BMP) tests as well as albumin, alkaline phosphatase, ALT, AST, GGT, bilirubin, calcium, cholesterol and triglycerides, lactate dehydrogenase, phosphate, total serum protein, and uric acid.
17-Creatinine /Renal function panel	Select box if 1) any of these terms are used; or 2) if terms such as BUN-to-Creatinine ratio; BUN/Creatinine; or BUN/Cr are stated. Creatinine may be abbreviated as 'Cr.' Select box for blood (serum or plasma) Creatinine test. DO NOT select box for urine Creatinine; urine Albumin-to-Creatinine ratio; Creatinine Clearance; or Creatine Kinase.
18-Culture, blood	A blood culture determines if microorganisms, such as bacteria or fungi, are present in the blood. Often obtained in sets of 2 or 3 at the same time. Might be abbreviated as BC, blood Cx, or blood C&S (culture and sensitivity).
19-Culture, throat	A throat culture is a test to check for a bacterial or fungal infection in the throat. A sample swabbed from the throat is put in a special cup (culture) that allows infections to grow. Might be abbreviated as throat Cx or throat C&S (culture and sensitivity). Do not select box for rapid strep test.
20-Culture, urine	The urine culture test detects and identifies bacteria and yeast in the urine and is used to diagnose a urinary tract infection (UTI). A mid-stream clean catch urine sample is submitted to the lab; sometimes a urine sample is obtained via catheter. Might be abbreviated urine Cx or urine C&S (culture and sensitivity).
21-Culture, other	Might be abbreviated Cx or C&S-culture and sensitivity.

22-Glucose, serum	Select box for **blood** Glucose test. Do not select box for urine Glucose test. The serum glucose test measures the amount of glucose (sugar) in serum and plasma. A fasting blood glucose test may be abbreviated as FBG or FBS.
23- Gonorrhea test	Gonorrhea tests involve testing a sample of body fluid or urine to see if gonorrhea bacteria (*Neisseria gonorrhoeae*) are. These tests are used to screen for or confirm a gonorrhea infection. Gonorrhea tests include the following: nucleic acid amplification tests (NAAT); nucleic acid hybridization tests (DNA probe test); enzyme-linked immunosorbent assay (ELISA, EIA); gram stain; and gonorrhea culture. Often abbreviated as GC.
24-HbA1c (Glycohemoglobin)	The HbA1c or glycohemoglobin/glycosylated hemoglobin test measures the percentage of hemoglobin that is bound with glucose molecules and is usually reported as a percent. It is different from the hemoglobin (Hgb) test that may be a part of the complete blood count (CBC) or performed as a single test which is generally reported in g/dL (grams per deciliter). HbA1c is directly tied to the concentration of glucose in the blood. This test provides an assessment of average blood sugar control in patients with diabetes during the 60-90 days prior to the test. It is also commonly known as the hemoglobin A1C measurement. The laboratory abbreviation is HbA1c and it is also known as A1C. Note that HbA1c is expressed as a percent and hemoglobin is measured in grams per deciliter.
25- Hepatitis panel	This panel tests for infection by one of the hepatitis viruses. Select box if Hep A, HAV, Hep B, HBV, HBsAg, Hep C or HCV are listed.
26-HIV test	Also known as AIDS test, AIDS screen, and HIV serology. Antibodies to the HIV virus are often detected by an HIV screening test called an ELISA. The ELISA test is repeated if positive. The ELISA method is very sensitive but requires another test, a Western Blot, to confirm the results.
27-HPV DNA test	The HPV DNA test detects the presence of high risk human papillomaviruses that are associated with cancer and is performed by collecting cells from mucosal tissue such as the cervix in women. Might be abbreviated as HPV or HRHPV and might have a positive or negative sign after the abbreviation.
28-Lipid profile	A lipid profile includes any of the following tests: cholesterol, LDL, HDL, cholesterol/HDL ratio, triglycerides, coronary risk profile, and lipid profile.
29- Liver enzymes/Hepatic function panel	Select box if liver function tests, LFTs, AST, ALT, aspartate aminotransferase or alanine aminotransferase are listed.
30-PAP test	A PAP test (also called a PAP smear, cervical smear, cervical cytology) is a screening test used in gynecology to detect pre-cancerous and cancerous cells of the cervix and is performed

	during a pelvic exam (however, all pelvic exams do not necessarily include Pap testing—only mark if the terms Pap test, Pap smear, cervical smear or cervical cytology are used.
31-Pregnancy/HCG test	A pregnancy test may be done on either urine or blood. This test measures hCG, or human chorionic gonadotropin, a hormone that is produced during pregnancy. Include: hCG, beta hCG, total hCG, and total beta hCG.
32-PSA (prostate specific antigen)	A PSA test is used to screen for or monitor prostate cancer and measures the amount of prostate-specific antigen in the blood.
33-Rapid strep test	For a rapid strep test, the throat and tonsils are swabbed to collect bacteria from the infected area for testing. The bacteria are analyzed to see whether Group A strep (streptococcal) bacteria are causing the sore throat.
34- TSH/Thyroid panel	Select box if T3, T4, thyroxine, Free T4, FT4 or thyroid function panel listed.
35-Urinalysis	A urinalysis checks different components of urine to identify potential problems. More than 100 different tests can be done on urine, including specific gravity, color, clarity, odor, pH, protein, and glucose. Include “clean catch” urine sample. Often abbreviated as U/A or urine dip.
36-Vitamin D Test	Select box if 25-Hydroxyvitamin D, 25OHD, 25-hydroxycholecalciferol, or 25-hydroxyergocalciferol are listed.
Imaging:	
37-Bone mineral density	A bone mineral density test uses imaging technology to measure the amount of calcium in a specific region of the bone and is used to detect osteoporosis.
38-CT scan	A computed tomography (CT) scan uses X-rays to make detailed pictures of structures inside the body. It can be performed on the head, chest, abdomen, pelvis, bone, and spinal cord. In some cases, a dye (contrast material) may be used.
39-Echocardiogram	During an echocardiogram, sound waves are used to create a moving picture of the heart. The picture is much more detailed than an x-ray image and involves no radiation exposure. Often referred to simply as and “echo.”
40-Ultrasound	This includes ultrasound tests other than an echocardiogram, such as fetal, pelvic, and abdominal ultrasound tests. Might be abbreviated US or U/S.
41-Mammography	Mammography or mammogram is a type of x-ray that is used for breast cancer screening and to evaluate abnormalities in the breast such as lumps or masses It might be abbreviated as

	MMG.
42-MRI	Magnetic resonance imaging (MRI) is a test that uses a magnetic field and pulses of radio wave energy to make pictures of organs and structures inside the bodyMRI may also show problems that cannot be seen with other imaging methods.
43-X-ray	An X-ray is a picture of structures and organs in the body produced by focusing X-rays (a form of radiation) focused into a beam.
Procedures:	
44-Audiometry	Audiometry is the testing of hearing ability, involving thresholds and differing frequencies.
45-Biopsy	During a biopsy, a small piece of tissue is removed for microscopic examination and/or culture to help the provider make a diagnosis. There are 3 types of biopsies: needle, open, and closed. “Excisional biopsy” should be included under biopsy rather than excision.
46-Cardiac stress test	Cardiac stress tests are used in medicine and cardiology to measure the heart's ability to respond to external stress in a controlled clinical environment. The stress response is induced by exercise or drug stimulation. Cardiac stress tests compare the coronary circulation while the patient is at rest with the same patient's circulation observed during maximum physical exertion, showing any abnormal blood flow to the heart's muscle tissue (the myocardium).
47-Colonoscopy	Colonoscopy is the endoscopic examination of the colon and the part of the small bowel with a camera on a flexible tube passed through the anus in order to detect polyps, malignant tumors, and sources of bleeding. It may provide a visual diagnosis (e.g. ulceration, polyps) and grants the opportunity for biopsy or removal of suspected lesions. Colonoscopy is similar to, but not the same as, sigmoidoscopy—the difference being related to which parts of the colon each can examine.
48- Cryosurgery (cryotherapy)/ Destruction of tissue	Select box if LN2, liquid nitrogen, TCA or trichloroacetic acid listed.
49-EKG/ECG	An electrocardiogram (EKG or ECG) is a test that checks for problems with the electrical activity of the heart. An EKG/ECG translates the heart’s electrical activity into line tracings on paper.
50-Electroencephalogram (EEG)	Electroencephalogram (EEG) is the recording of electrical activity along the scalp. In neurology, the main diagnostic application of EEG is in the case of epilepsy, as epileptic activity can create clear abnormalities on a standard EEG study. A secondary clinical use of EEG is in the diagnosis of coma, encephalopathies, and brain death.

51-Electromyelogram (EMG)	Electromyography (EMG) is a technique for evaluating and recording the electrical activity produced by skeletal muscles. Do not include nerve conduction study (NCS) or nerve conduction velocity (NCV) test.
52-Excision of tissue	Excision of tissue is the removal of tissue (e.g., polyps, cysts, and moles) by cutting. In surgery, an excision (or resection) is the complete removal of an organ or a tumor, as opposed to a biopsy.
53-Fetal monitoring	Fetal monitoring lets the health care provider monitor the baby's heartbeat in the uterus. The procedure is most commonly done with monitors placed on the mother's abdomen. Fetal monitoring might be abbreviated as EFM (electronic fetal monitoring) or NST (non-stress test).
54-Peak flow	The peak expiratory flow (PEF), also called peak expiratory flow rate (PEFR) is a person's maximum speed of expiration, as measured with a peak flow meter, a small, hand-held device used to monitor a person's ability to breathe out air. It measures the airflow through the bronchi and thus the degree of obstruction in the airways. It is usually used for asthma patients.
55-Sigmoidoscopy	Sigmoidoscopy is the minimally invasive medical examination of the large intestine from the rectum through the last part of the colon. There are two types of sigmoidoscopy, flexible sigmoidoscopy, which uses a flexible endoscope, and rigid sigmoidoscopy, which uses a rigid device. The flexible endoscope transmits an image of the inside of the rectum and colon, so the provider can carefully examine the lining of these organs. A sigmoidoscopy is similar to, but not the same as, a colonoscopy. A sigmoidoscopy only examines up to the sigmoid, the most distal part of the colon, while colonoscopy examines the whole large bowel.
56-Spirometry	Spirometry measures how much air a patient can inhale and exhale. It also measures how fast a patient can exhale and is a common test used to diagnose asthma, chronic obstructive pulmonary disease (COPD) and certain other conditions that affect breathing. It may also be used periodically to check how well a patient's lungs are working once the patient is being treated for a chronic lung condition.
57-Tonometry	In ophthalmology, tonometry is the procedure eye care professionals perform to determine the intraocular pressure (IOP), the fluid pressure inside the eye. It is an important test in the evaluation of patients with glaucoma. Most tonometers are calibrated to measure pressure in millimeters of mercury (mmHg).
58- Tuberculosis skin testing/PPD	Select box if TB skin testing is listed or PPD was placed; DO NOT select box if TB skin test/PPD was read.
59- Upper gastrointestinal	EGD is abbreviation for esophagogastroduodenoscopy.

endoscopy/EGD	
Treatments:	
60-Cast, splint, wrap	This includes both hard and soft wraps used to support and protect injured bones, ligaments, tendons, and other tissues. A cast is a rigid or flexible dressing made of plaster or fiberglass, molded to the body while pliable and hardening as it dries to give firm support. A splint is a rigid or flexible appliance used to maintain in position a displaced or moveable part, or to keep in place and protect an injured part. A wrap is an elastic bandage (also known as an ACE bandage, elastic wrap, compression bandage or crepe bandage) is a "stretchable bandage used to create localized pressure." Elastic bandages are commonly used to treat muscle sprains and strains by reducing the flow of blood to a particular area by the application of even stable pressure which can restrict swelling at the place of injury.
61-Complementary alternative medicine (CAM)	Complementary alternative medicine (CAM) includes medical interventions neither widely taught in medical schools nor generally available in physician offices or hospitals (e.g., acupuncture, chiropractic, homeopathy, massage or herbal therapies).
62-Durable medical equipment	Durable medical equipment is that which can withstand repeated use (i.e., could normally be rented and used by successive patients); is primarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in the patient's home (e.g., cane, crutch, walker, wheelchair, glucose monitor).
63-Home health care	Home health care includes services provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or for maximizing the level of independence while minimizing the effects of disability and illness (including terminal illness). Services may include skilled nursing care; help with bathing, using toilet or dressing provided by home health aides; and physical therapy, speech language pathology services, and occupational therapy.
64-Mental health counseling, excluding psychotherapy	Mental health counseling includes general advice and counseling about mental health issues and education about mental disorders. It includes referrals to other mental health professionals for mental health counseling, but excludes psychotherapy.
65- Occupational therapy	Occupational therapy is the use of treatments to develop, recover, or maintain the daily living and work skills of people with a physical, mental or developmental condition. Might be abbreviated OT.

66-Physical therapy	Physical therapy includes treatments using heat, light, sound, or physical pressure or movement (e.g., ultrasonic, ultraviolet, infrared, whirlpool, diathermy, cold or manipulative therapy). Might be abbreviated PT.
67-Psychotherapy	Psychotherapy includes all treatment involving the intentional use of verbal techniques to explore or alter the patient's emotional life in order to effect symptom reduction or behavior change.
68-Radiation therapy	Radiation therapy uses high-energy radiation to shrink tumors and kill cancer cells. X-rays, gamma rays, and charged particles are types of radiation used for cancer treatment. The radiation may be delivered by a machine outside the body (external-beam radiation therapy, might be abbreviated as RT, XRT, IMRT, IGRT, 3D-CRT), or it may come from radioactive material placed in the body near cancer cells (internal radiation therapy, also called brachytherapy). Systemic radiation therapy uses radioactive substances, such as radioactive iodine, that travel in the blood to kill cancer cells.
69-Wound care	Wound care includes the cleaning, debridement, and dressing of burns and the repair of lacerations with skin tape or sutures. It only Includes the removal of foreign bodies only if a wound exists. If an object is removed from an orifice (e.g., ear, nose), then enter "foreign body removal" in "Other service."
Health education/Counseling:	**This category includes education or counseling provided at the visit as well as orders or referrals for education/counseling for the condition or topic.**
70- Alcohol abuse counseling	Select box if education counseling is ordered or provided around alcohol abuse. Alcohol might be abbreviated EtOH.
71-Asthma	Asthma education includes providing information regarding the elimination of allergens that may exacerbate asthma or other activities that could lead to an asthma attack or instruction on the use of medication, such as an inhaler.
72-Asthma action plan given to patient	An asthma action plan (also called a management plan, might be abbreviated AAP) is a written plan that a patient (or the patient's parents) develops with his or her doctor to help control his or her asthma. The asthma action plan shows the patient's daily treatment, such as what kind of medicines to take and when to take them. It also describes how to control asthma long term and how to handle worsening asthma, or attacks. The plan explains when to call the doctor or go to the ED.
73- Diabetes education	Diabetes education includes helping patients manage their insulin (e.g., insulin pump therapy), blood sugar (e.g., glucose monitoring), diet, and fitness routine. Might be abbreviated DM education/counseling.

74-Diet/Nutrition	Diet or nutrition education includes any topic related to the foods and/or beverages consumed by the patient. Examples include general dietary guidelines for health promotion and disease prevention, dietary restrictions to treat or control a specific medical problem or condition and dietary instructions related to medications. Includes referrals to other health professionals, for example, dietitians and nutritionists.
75-Exercise	Exercise education includes any topics related to the patient's physical conditioning or fitness. Examples include information aimed at general health promotion and disease prevention and information given to the patient to treat or control a specific medical condition. It includes referrals to other health and fitness professionals, but excludes referrals for physical therapy.
76-Family planning/Contraception	Family planning allows individuals and couples to anticipate and attain their desired number of children and manage the spacing and timing of their pregnancies. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. Contraception is the deliberate use of techniques to prevent pregnancy as a consequence of sexual intercourse. The major forms of contraception are: barrier methods, of which the commonest is the condom; the contraceptive pill (often abbreviated OCPs or BCPs), which contains synthetic sex hormones that prevent ovulation in the female; intrauterine devices (often abbreviated as IUD or IUS); and male or female sterilization. It also includes information given to the patient to assist in conception or intended to help the patient understand how to prevent conception.
77- Genetic counseling	Might be in chart as refer to genetic counselor or refer for genetic counseling.
78-Growth/Development	Growth and development counseling refers to any topics related to the growth and development of a child.
79-Injury prevention	Education on injury prevention refers to any topic aimed at minimizing the chances of injury in one's daily life. It may include issues as diverse as drinking and driving, seat belt use, child safety, avoidance of injury during various physical activities, and the use of smoke detectors.
80-STD prevention	STD (sexually transmitted diseases) or STI (sexually transmitted infections) prevention includes educating patients about STD/STI transmission, safe sex, and condom use; offering or encouraging testing of patients for syphilis, gonorrhea, Chlamydia, and HIV; and partner notification.
81-Stress management	Stress management counseling refers to information intended to help patients reduce stress through exercise, biofeedback, yoga, etc. It includes referrals to other health professionals for the purpose of coping with stress.

82- Substance abuse counseling	Select box if education counseling is ordered or provided 1) around substance use/abuse; illicit drug use, or injection/intravenous drug use (IDU/IVDU/IVDA); or 2) around use of a specific substance (e.g., cocaine use, opioid dependence), not including tobacco/nicotine or alcohol.)
83-Tobacco use/Exposure	Education on tobacco use and exposure refers to Information given to the patient on issues related to tobacco use in any form, including cigarettes, cigars, snuff and chewing tobacco and on the exposure to tobacco in the form of "secondhand smoke." It includes information on smoking cessation as well as prevention of tobacco use as well as referrals to other health professionals for smoking cessations programs.
84-Weight reduction	Education on weight reduction refers to Information given to the patient to assist in the goal of weight reduction. It includes referrals to other health professionals for the purpose of weight reduction.
Other services not listed: 85-Other	Enter any other examinations/screenings, laboratory tests, imaging, procedures, treatments, and health education/counseling that were ordered or provided at this visit and not listed above.

MEDICATIONS & IMMUNIZATIONS

List **up to 30 medications** ordered, supplied, administered, or continued at this visit. Include prescription and over-the-counter (OTC) drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements. For each drug listed, record if it was new or continued.

Record the exact drug name (brand or generic) written on any prescription or on the medical record. Additional information such as **dosage, strength, or regimen is not required**. For example, the medication might be in the form of pills, injections, salves or ointments, drops, suppositories, powders, or skin patches, but this information should not be entered.

You may enter broad drug classes, such as "laxative," "cough preparation," "analgesic," "antacid," "birth control pill," or "antibiotic" but only when a specific drug name is not recorded in the medical record.

Medication, broadly defined, includes the specific name of any:

- Prescription and over-the-counter medications, anesthetics, hormones, vitamins, immunizations, allergy shots, and dietary supplements
- Medications and immunizations which the physician/provider ordered or provided prior to this visit and instructs or expects the patient to continue taking regardless of whether a "refill" is provided at the time of visit

If **more than 30 medications** are listed, then record according to the following level of priority:

1. All new medications (including OTC drugs)/immunizations

2. All continued medications (including OTC drugs)/immunizations

If **no medication** was prescribed, provided, or continued, then enter "0" and continue.

PROVIDERS AND DISPOSITION

Enter all providers seen during this visit, separate with commas.

Provider	Definitions
1. Physician	A physician is a person who has graduated from medical school and is licensed to practice medicine. Include both MDs and DOs.
2. Physician assistant (PA)	A physician assistant (PA) is a medical professional who is nationally certified and state-licensed to practice medicine.
3. Nurse practitioner (NP)	A nurse practitioner (NP) is an Advanced Practice Registered Nurse (APRN) who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of an RN.
4. RN/LPN	A registered nurse (RN) is a nurse who has graduated from a nursing program at a college or university and has passed a national licensing exam to obtain a nursing license. An LPN (licensed practical nurse) is a nurse who has completed a basic level of training and is licensed to provide routine care to sick people.
5. Mental health provider	Include psychologists, counselors (e.g., Certified Alcohol Counselor [CAC]), social workers, and therapists who provide mental health counseling. Exclude psychiatrists.
6. Other	Select this box, if health care was provided by a provider not listed above. Exclude those who provided ancillary services, e.g., x-ray technician, phlebotomist, respiratory therapist.
7. None	There is no documentation in the chart that a health care provider was seen during this visit.

Enter estimated time spent with sampled provider

Include here the length of time the physician/CHC provider spent with the patient. DO NOT include the time the patient spent waiting to see the physician/CHC provider or receiving care from someone other than the physician/CHC provider. For example, DO NOT include the time someone other than the sampled provider spent giving the patient an inoculation or the time a technician spent administering an

electrocardiogram. It is entirely possible that for visits such as these, the patient would not see the physician/CHC provider at all. In that case, “0” minutes should be recorded. DO NOT include physician’s/CHC provider’s time spent preparing for a patient such as reviewing the patient’s medical records or test results before seeing the patient.

If more than one patient is seen by the physician/CHC provider at the same time, apply the following rule:

If the physician/CHC provider can easily separate the time spent with each (e.g., 3 minutes with one and 27 minutes with the other), he/she should record that on the Patient Record forms. If the physician/CHC provider cannot easily estimate how much time was spent with each, he/she should divide the total time equally among the patients seen together.

Disposition	**Definitions**
1. Return to referring physician	Patient was referred for this visit from another physician/provider whom they will return to for follow-up care.
2. Refer to other physician	Patient was instructed to consult or seek care from another physician/provider. The patient may or may not return to this office/CHC/clinic at a later date.
3. Return in less than 1 week	Patient was told to schedule an appointment or was given an appointment to return to this office/CHC/clinic in less than 1 week.
4. Return in 1 week to less than 2 months	Patient was told to schedule an appointment or was given an appointment to return to this office/CHC/clinic in 1 week to less than 2 months.
5. Return in 2 months or greater	Patient was told to schedule an appointment or was given an appointment to return to this office/CHC/clinic in 2 months or greater.
6. Return at unspecified time	Patient was told to schedule an appointment or was given an appointment to return to this office/CHC/clinic, but the time was not specified in the chart.
7. Return as needed (p.r.n.)	Patient was not scheduled to return to this office/CHC/clinic at a specific time, but was instructed to return for care as needed (p.r.n.).
8. Refer to ER/Admit to hospital	Patient was referred to the emergency room (ER)/department (ED) for further evaluation and care immediately or the patient was admitted to the hospital as an inpatient.
9. Other	Any other disposition not included in the above list.

TESTS

Cholesterol test	**Definitions**
1-Yes	Enter "Yes" if there is documentation in the medical record that a total serum cholesterol test was drawn during the 12 months prior to this visit. A total cholesterol test measures all types of cholesterol in the blood. **Total cholesterol score is calculated by the following: HDL + LDL + 20% of the triglyceride level.** The total cholesterol test is included in a lipid profile/panel.
2-None found	Enter "None found" if there is no documentation in the medical record that a total serum cholesterol test was drawn during the 12 months prior to this visit.
HDL test	**Definitions**
1-Yes	Enter "Yes" if there is documentation in the medical record that a high density lipoprotein (HDL) test was drawn during the 12 months prior to this visit. The high density lipoprotein (HDL) test is included in a lipid profile/panel.
2-None found	Enter "None found" if there is no documentation in the medical record that a high density lipoprotein (HDL) test was drawn during the 12 months prior to this visit.
LDL test	**Definitions**
1-Yes	Enter "Yes" if there is documentation in the medical record that a low density lipoprotein (LDL) test was drawn during the 12 months prior to this visit. The low density lipoprotein (LDL) test is included in a lipid profile/panel.
2-None found	Enter "None found" if there is no documentation in the medical record that a low density lipoprotein (LDL) test was drawn during the 12 months prior to this visit.
Triglycerides test	**Definitions**
1-Yes	Enter "Yes" if there is documentation in the medical record that a triglycerides (TGS) test was drawn during the 12 months prior to this visit. The triglycerides (TGS) test is included in a lipid profile/panel.
2-None found	Enter "None found" if there is no documentation in the medical record that a triglycerides (TGS) test was drawn during the 12 months prior to this visit.
HbA1c test	**Definitions**

1-Yes	Enter “Yes” if there is documentation in the medical record that an HbA1c or A1C or glycohemoglobin test was drawn during the 12 months prior to this visit. The HbA1c or A1C or glycohemoglobin test measures the amount of glucose that is bound to hemoglobin and is usually reported as a percent. It is usually ordered for patients who have diabetes and is different from the hemoglobin (Hgb) test that may be a part of the complete blood count (CBC) or performed as a single test which is generally reported in g/dL (grams per deciliter).
2-None found	Enter “None found” if there is no documentation in the medical record that an HbA1c or A1C or glycohemoglobin test was drawn during the 12 months prior to this visit.
Blood glucose test	**Definitions**
1-Yes	Enter “Yes” if there is documentation in the medical record that a blood glucose (BG) test was drawn during the 12 months prior to this visit. Include all blood glucose tests regardless of whether the patient was fasting (FBG, FBS) or not.
2-None found	Enter “None found” if there is no documentation in the medical record that a blood glucose test was drawn during the 12 months prior to this visit.
Serum creatinine test	**Definitions**
1-Yes	Enter “Yes” if there is documentation in the medical record that a serum creatinine test was drawn during the 12 months prior to this visit. The serum creatinine test is included in the basic metabolic panel (BMP), comprehensive metabolic panel (CMP), and renal function panel (RFP).
2-None found	Enter “None found” if there is no documentation in the medical record that a serum creatinine test was drawn during the 12 months prior to this visit.

C. DEFINITIONS OF CERTAIN TERMS USED IN NAMCS

Ambulatory patient -- A non-institutionalized person who comes to the doctor’s office (definition of office below) for personal health reasons.

Continuity of care -- Continuity of care is a goal of health care achieved through an interdisciplinary process involving patients, families, health care professionals, and providers in the management of a coordinated plan of care. Based on changing needs and available resources, the process optimizes quality outcomes in the health status of patients. It may involve professionals from many different disciplines within multiple systems.

Drug mention(s) --The physician's entry of a pharmaceutical agent ordered or provided--by any route of administration--for prevention, diagnosis, or treatment. Generic as well as brand-name drugs are included. Along with all new drugs, the physician also records continued medications if the patient was specifically instructed or expected to continue the medication.

Drug visit -- A drug visit is a visit at which medication was prescribed or provided by the physician.

Office – Place which the sampled provider identifies as a location for ambulatory practice, customarily including consulting, examination, and/or treatment spaces which patients associate with the particular provider. The office may be part of a free-standing clinic, or one of several offices operated by a group or partnership, neighborhood/community health center, or family planning clinic.

In some instances, the office might be owned by a hospital and these are still in-scope for NAMCS.

Out-of-scope office:

-- Hospital outpatient department or emergency department.

– Offices in Federal Government operated facilities, such as a VA clinic.

– Offices in on-site facilities that are operated by a large institution and restricted to that population, such as an industrial clinic serving employees of a particular company or a university clinic serving only students and staff.

Visit -- A direct, personal exchange between ambulatory patient and the sampled provider (or members of his/her staff) for the purpose of seeking care and rendering health services.

PATIENTS

In-scope -- All ambulatory patients seen by the physician or members of his/her staff in the physician's office(s) or seen by the sampled provider (physician or mid-level provider) in the community health center at any time during the one-week reporting period. [Note: Visits to community health centers are NOT included on the 2016 NAMCS Public Use Data File. They are expected to be released separately at a later date.] If a patient is seen by a sampled provider's staff, the staff member must be supervised by the sampled provider (versus just working in the same practice), in order to be included in NAMCS.

Out-of-scope: Patients seen by the sampled provider in a hospital, nursing home, or other extended-care institution, or the patient's home. *[**Note:** If a doctor has a **private** office (which fits the definition of "office") located in a hospital, the ambulatory patients seen there would be considered "in-scope."]*

– Patients who call on the telephone and receive advice from the sampled provider.

– Patients who come to the office only to leave a specimen, pick up insurance forms, or pay their bills.

– Patients who come to the office only to pick up medications previously prescribed by the sampled provider.

PROVIDERS

In-Scope -- All sampled providers currently in practice who spend any time caring for ambulatory patients at an office location (see definition of office above). In offices, sampled providers include physicians (MDs and DOs). In community health centers, sampled providers include physicians (MDs and DOs) along with physician assistants, nurse practitioners, and nurse mid-wives.

Out-of-Scope -- Those sampled providers who treat patients only indirectly. For office-based physicians, out-of-scope will include physician specialists in anesthesiology, pathology and forensic pathology, radiology, therapeutic radiology, and diagnostic radiology. [Note: A more detailed list is available by contacting the Ambulatory and Hospital Care Statistics Branch.] In community health centers,

out-of-scope includes non-medical providers (such as dentists, optometrists, and social workers).The following kinds of physicians are also out-of-scope:

- Physicians employed full-time by the Federal Government and having no private practice (e.g., physicians who work for the VA).

- Physicians employed full-time by an institution to serve its own population. The physician does not see ambulatory patients from outside the institutional community. For example, the physician works for Ford Motor Company, and provides care only to ambulatory patients and their families employed by Ford.

- Physicians who spend no time during a normal week seeing ambulatory patients (e.g., physicians who exclusively teach or are engaged in research).

- Physicians employed full-time by a hospital working with inpatients, in an ED or OPD, with no private practice.

- Physicians in military service, with no private practice.

- Physicians who treat only institutionalized patients (e.g., patients in nursing homes, hospitals, and prisons).

Physician specialty -- Principal specialty (including general practice) as designated by the physician at the time of the survey. Those physicians for whom a specialty was not obtained were assigned the principal specialty recorded in the Master Physician files maintained by the AMA or AOA.

Metropolitan status — Physicians are classified by their location in metropolitan statistical area as follows:

Metropolitan statistical area (MSA)—As defined by the U.S. Office of Management and Budget, the definition of an individual MSA involves two considerations: first, a city or cities of specified population, that constitute the central city and identify the county in which it is located as the central county; second, economic and social relationships with “contiguous”’ counties that are metropolitan in character so that the periphery of the specific metropolitan area may be determined. MSAs may cross state lines. In New England, MSAs consist of cities and towns rather than counties.

Non-MSA—Non-MSA areas are those not defined as MSAs, including rural and micropolitan areas.

Region of practice location -- The four geographic regions which correspond to those used by the U.S. Census Bureau, are as follows:

Region	States Included
Northeast	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
Midwest	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
South	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
West	Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, Alaska, Hawaii

APPENDIX II
REASON FOR VISIT CLASSIFICATION

NOTE: The Reason for Visit Classification used for the 2016 NAMCS public use micro-data file is the same as that used for the 2015 National Ambulatory Medical Care Survey public use micro-data file and is available here.

APPENDIX III

A. GENERIC CODES AND NAMES IN NUMERIC ORDER

The Generic Codes and Names List for the 2016 NAMCS public use micro-data file is the same as that used for the 2016 National Hospital Ambulatory Medical Care Survey Emergency Department public use micro-data file and is available here.

B. DRUG ENTRY CODES AND NAMES IN NUMERIC ORDER

The Drug Entry Codes and Names List for the 2016 NAMCS public use micro-data file is the same as that used for the 2016 National Hospital Ambulatory Medical Care Survey Emergency Department public use micro-data file and is available here.

C. MULTUM LEXICON END-USER LICENSE AGREEMENT

The Multum Lexicon End-User License Agreement for the 2016 NAMCS public use micro-data file is the same as that used for the 2015 National Ambulatory Medical Care Survey public use mciro-data file and is available here.

D. MULTUM CLASSIFICATION OF THERAPEUTIC CLASSES (DRUG CATEGORIES)

The Multum Classification of Therapeutic Classes for the 2016 NAMCS public use-micro-data file is the same as that used for the 2016 National Hospital Ambulatory Medical Care Survey Emergency Department public use micro-data file and is available here.