

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4098	Date: August 3, 2018
	Change Request 10520

SUBJECT: Update to the Fiscal Intermediary Shared Systems (FISS) Outpatient Provider Specific File (OPSF) for Outpatient Prospective Payment System (OPPS) Hospitals and OPPS Pricer Interface

I. SUMMARY OF CHANGES: The OPPS OPSF and OPPS Pricer interface needs to add a new field "Payment Model Adjustment" to be sent from the Shared System as part of the Pricer input buffer.

EFFECTIVE DATE: January 1, 2019

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 7, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/50.1/Outpatient Provider Specific File

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Number	Requirement	Responsibility									
		A/B MAC		H H H	M A C	D M E	Shared- System Maintainers				Other
		A	B				F I S S	M C S	V M S	C W F	
10520.4	The OPSS Pricer shall use the new PMA field to apply the Payment Model Adjustment, when present, for applicable model lines under OPSS payment processing beginning January 1, 2019.										OPSS Pricer
10520.5	The Medicare Shared System Maintainer shall auto-populate 1.00000 into the "PMA" field when a new record is created.					X					
10520.6	The Medicare Shared System Maintainer shall edit the 'PMA' field to ensure that if any data is present it must be in a 6 digit numeric value (9.99999 format) when a record is created, copied or updated for providers.					X					
10520.6.1	The Medicare Shared System Maintainer shall exclude Veterans Administration (VA) Demo providers (identified with an Oscar number of '670899' or with a 'V' in the fifth position of the Oscar number.					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC		H H H	M A C	D M E	C D I				
		A	B								
	None										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Yvonne Young, YVONNE.YOUNG@cms.hhs.gov , Fred Rooke, fred.rooke@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

50.1 - Outpatient Provider Specific File

(Rev.4098, Issued 08-03-18, Effective: 01-01-19, Implementation 01-07-19)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

NOTE: All data elements, whether required or optional, must have a default value of “0” (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPSS period. For subsequent OPSS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The created/run date of the PROV report for submittal to CO.
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeroes or contain a termination date. (Once the official “tie-out” notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting contractor ceased servicing the provider in question).

49	X(1)	Waiver Indicator	<p>Enter a “Y” or “N.”</p> <p>Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS.</p> <p>N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.</p>
50-54	9(5)	Intermediary Number	Enter the Contractor #.
55-56	X(2)	Provider Type	<p>This identifies providers that require special handling. Enter one of the following codes as appropriate.</p> <p>00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type “06” is effective until July 1, 2006. At that point, provider type “06” will no longer be used. Instead, contractors will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital</p>

			<p>38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998</p> <p>40 Hospital Based ESRD Facility</p> <p>41 Independent ESRD Facility</p> <p>42 Federally Qualified Health Centers</p> <p>43 Religious Non-Medical Health Care Institutions</p> <p>44 Rural Health Clinics-Free Standing</p> <p>45 Rural Health Clinics-Provider Based</p> <p>46 Comprehensive Outpatient Rehab Facilities</p> <p>47 Community Mental Health Centers</p> <p>48 Outpatient Physical Therapy Services</p> <p>49 Psychiatric Distinct Part</p> <p>50 Rehabilitation Distinct Part</p> <p>51 Short-Term Hospital – Swing Bed</p> <p>52 Long-Term Care Hospital – Swing Bed</p> <p>53 Rehabilitation Facility – Swing Bed</p> <p>54 Critical Access Hospital – Swing Bed</p>
57	X(1)	Special Locality Indicator	<p>Indicates the type of special locality provision that applies.</p> <p>For End Stage Renal Disease (ESRD) facilities value “Y” equals low volume adjustment applicable.</p>
58	X(1)	Change Code For Wage Index Reclassification	<p>Enter “Y” if the hospital’s wage index location has been reclassified for the year. Enter “N” if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.</p>
59-62	X(4)	Actual Geographic Location—MSA	<p>Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank)(blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.</p>
63-66	X(4)	Wage Index Location—MSA	<p>The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.</p>
67-70	9V9(3)	Payment-to-Cost Ratio	<p>Enter the provider’s payment-to-cost ratio. Does not apply to ESRD Facilities.</p>
71-72	9(2)	State Code	<p>Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. Contractors shall enter a “10” for Florida’s State Code.</p> <p>List of valid State Codes is located in Pub. 10007, Chapter 2, Section 2779A1.</p>

73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs
74	X(1)	Quality Indicator Field	<p>Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPSS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital.</p> <p>Blank = Hospital does not meet criteria.</p> <p>Independent and Hospital-based End Stage Renal Disease (ESRD)Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP):</p> <p>Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction</p> <p>* Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator.</p>
75	X(1)	Filler	Blank.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	<p>Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio.</p> <p>Does not apply to ESRD Facilities.</p>
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ <u>3</u> <u>6</u> for Ohio, where the facility is physically located.

85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ <u>3 6</u> for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual Reclassified
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.
101	X(1)	Quality Indicator ESRD Children's Hospitals	Children's Hospitals for End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction
102-105	9V9(3)	Device department's Cost-to-Charge Ratio	Derived from the latest available cost report data. Does not apply to ESRD Facilities.
106-112	X(7)	Carrier/Locality code	The carrier/locality code for the provider service facility. The first five positions represent the carrier code and the last two positions represent the locality code.
113-117	9(5)	County Code	Enter the County Code. Must be 5 numbers.

118-122	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ <u>3 6</u> for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
<i>123-128</i>	<i>9V9(5)</i>	<i>Payment Model Adjustment (PMA)</i>	<i>Derived from payment model Technical Direction Letter.</i>
<i>129-162</i>	X(34)	FILLER	

The contractor enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to system's capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced coinsurance amount elected by the provider

The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).