

Limited Data Set (LDS) for Partial Hospitalization Program Services Paid Under the Hospital Outpatient Prospective Payment System (OPPS) Description, Fields, and Definitions

FILE DESCRIPTION

This file contains select claim level data and is derived from 2019 claims for partial hospitalization program (PHP) services furnished on or after January 1, 2019 through December 31, 2019. The file contains claims with dates of service January 1, 2019 through December 31, 2019 that were received, processed, and passed to the National Claims History file by June 30, 2020. This file includes 59,673 claims for PHP services furnished by hospitals and community mental health centers (CMHCs) that were paid under the OPPS. This is a flat file available on DVD. The record length is 9,997 and blocksize is 32,760.

Requests for clarification of file description, layout, and definitions only can be accepted at (410) 786-0378.

FILE NAME

Y287.OPPS.FN21.OPPSBEF2.T0201116

FILE LAYOUT

01 PUF-DATA.

10 PUF-TYPE	PIC X(4).
10 PUF-PROVIDER-NUMBER	PIC X(6).
10 BILL-TYPE	PIC X(2).
10 FROM-DATE	PIC S9(5) COMP-3.
10 DIAGNOSIS-CODES	PIC X(70).
10 OUTLIER-PAYMENT	PIC S9(9)V99 COMP-3.
10 SERVICE-LINE-COUNT	PIC S9(3) COMP-3.
10 SERVICE-LINE-GROUP.	
15 SERVICE-LINE	
OCCURS 0 TO 300 TIMES	
DEPENDING ON SERVICE-LINE-COUNT.	
25 SERVICE-REVENUE-CODE	PIC X(4).
25 SERVICE-HCPCS	PIC X(5).
25 SERVICE-DATE-OFFSET	PIC S9(3) COMP-3.
25 SERVICE-UNIT-COUNT	PIC S9(7) COMP-3.
25 SERVICE-TOTAL-CHARGES	PIC S9(9)V99 COMP-3.
25 SERVICE-COST	PIC S9(9)V99 COMP-3.
25 SERVICE-REV-PAYMENT	PIC S9(9)V99 COMP-3.

***CLAIM AND SERVICE LINE FIELD DEFINITIONS:
CLAIM FIELD DEFINITIONS***

PUF-TYPE: The claim type is either PHP hospital (PHSP) or PHP community mental health center (CMHC). These claim types are defined as:

PHSP: Records for partial hospitalization program (PHP) services furnished by hospitals, n= 48,739.

CMHC: Records for partial hospitalization program (PHP) services furnished by community mental health centers (CMHCs), n= 10,934.

PROVIDER-NUMBER: The identification number of the institutional provider certified by Medicare to provide services to the beneficiary. This number is not the NPI.

BILL-TYPE: The code derived by CWF to indicate the type of claim submitted by an institutional provider.

FROM-DATE: The date of service in quarter/year format.

DIAGNOSIS CODES: The principal diagnosis code, followed by other diagnoses, identifying the diagnosis, condition, problem or other reason for the outpatient encounter/visit shown in the medical record to be chiefly responsible for the services provided. The field contains up to 10 ICD-10-CM diagnosis codes of 7 characters each.

OUTLIER-PAYMENT: The 2019 outlier payment. Value is zero if there is no outlier payment.

SERVICE-LINE-COUNT: The number of revenue codes appearing on the claim.

SERVICE LINE FIELD DEFINITIONS

SERVICE-REVENUE-CODE: The provider-assigned revenue code for each cost center for which a separate charge is billed. A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology) or within a CMHC. Revenue center code “0001” is used to identify the claim “totals” line.

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SERVICE-HCPCS: Healthcare Common Procedure Coding System (HCPCS) code for an item or service is a collection of codes that represent procedures.

SERVICE-DATE-OFFSET: The number of days from the actual claim date of service. The actual claim date of service is not provided except in quarter/year format, and can be found in the “FROM-DATE” field. This “SERVICE-DATE-OFFSET” field can be used to determine

when line items were provided in comparison to other line items on the claim. The value “-999” will be used to indicate that the original line date of service was missing from the data.

SERVICE-UNIT-COUNT: The number of units of the item or service delivered.

SERVICE-TOTAL-CHARGES: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.

SERVICE-COST: The charges adjusted to cost using the hospital’s specific cost center cost-to-charge ratio or the CMHC’s overall cost-to-charge ratio.

SERVICE-REV-PAYMENT: The computed total 2019 OPPS payment for a line item, including deductible, coinsurance, and program payment.