***Limited Data Set for Hospital Outpatient Prospective Payment System (OPPS)***
***Description, Fields, and Definitions***

| ***Configuration*** | ***Filename*** | ***Filename Description*** |
|---|---|---|
| ***Final Policy*** | Y287.OPPS.FN23.OPPSBEF1.VC221014 | This file includes 112,802,992 claims for services paid under the OPPS, including multiple and single claims. The CCRs used to estimate cost are those based on our proposal to use cost report data with cost reporting periods prior to the PHE. |
| ***Additional File*** | Y287.OPPS.FN23.OPPSBEF1. VC221025 | This file includes 113,117,519 claims for services paid under the OPPS, including multiple and single claims. The CCRs used to estimate cost are those based on what would be our standard cost report data update, including cost reporting periods during the PHE. |
| These files contain select claim level data and are derived from 2021 hospital outpatient PPS claims, updated through June 2022, that is, claims for services furnished on or after January 1, 2021 through December 31, 2021 that were received, processed, paid, and passed to the National Claims History file by June 30, 2022. These are flat files available on DVD. The record length is 13,603 and the blocksize is 32,760.<br><br>Requests for clarification of file description, layout, and definitions can only be accepted at (410) 786 - 6719. | | |

*The following information is the same for both the final policy and additional runs:*

***FILE LAYOUT***

| | |
|---|---|
| 01 PUF-DATA. | |
| 10 PUF-TYPE | PIC X(4). |
| 10 PUF-PROVIDER-NUMBER | PIC X(6) |
| 10 WAGE-INDEX | 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-HCPCS-INITL-MDFR-CD | PIC X(2). |
| 25 SERVICE-HCPCS-2ND-MDFR-CD | PIC X(2). |
| 25 SERVICE-HCPCS-3RD-MDFR-CD | PIC X(2). |
| 25 SERVICE-HCPCS-4TH-MDFR-CD | PIC X(2). |
| 25 SERVICE-HCPCS-5TH-MDFR-CD | PIC X(2). |
| 25 SERVICE-REV-CNTR-PACK-IND-CD | PIC X. |
| 25 SERVICE-MJMC | PIC X. |
| 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***

TYPE: The claim type is either multi-major (MMAJ), multi-minor (MMIN), single major (SMAJ), or single minor (SMIN).

Please refer to the OPPS CY 2023 claims accounting for a full discussion of the different claim types listed above that make up the data in this file. The claims accounting file is provided as a supporting document to the OPPS rule and can be accessed via the CMS website for the OPPS at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

- Click on 'Hospital Outpatient Regulations and Notices', located on the left side of the page
- Choose 'CMS-1772-FC' from the list
- Scroll down the page for '2023 NFRM OPPS Claims Accounting' link

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

WAGE-INDEX: The CBSA pre-reclassification wage index that CMS used to standardize claim service costs for geographic differences in labor costs for the provider in 1.4 digit format, including the decimal.

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: 2021 outlier payment. The 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). 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-HCPCS-INITL-MDFR-CD: Revenue Center HCPCS Initial Modifier Code. A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the claim.

SERVICE-HCPCS-2ND-MDFR-CD: Revenue Center HCPCS Second Modifier Code. A second modifier to the HCPCS further identifying the specific procedure for the claim.

SERVICE-HCPCS-3RD-MDFR-CD: Revenue Center HCPCS Third Modifier Code. A third modifier to the HCPCS further identifying the specific procedure for the claim.

SERVICE-HCPCS-4TH-MDFR-CD: Revenue Center HCPCS Fourth Modifier Code. A fourth modifier to the HCPCS further identifying the specific procedure for the claim.

SERVICE-HCPCS-5TH-MDFR-CD: Revenue Center HCPCS Fifth Modifier Code. A fifth modifier to the HCPCS further identifying the specific procedure for the claim.

SERVICE-REV-CNTR-PACK-IND-CD: The code used to identify those services that were packaged/bundled with another service in the claim year. We provide this indicator to help users

identify token charges (3). The packaging information may not coincide with services that will be packaged in the prospective payment year.

0 - Not packaged
1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes)
2 – Packaged as part of partial hospital per diem or daily mental health service per diem
3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < $1.01)
4 – Packaged as part of drug administration APC payment (v6.0 – v7.3 only)

SERVICE-MJMC: Each HCPCS code has an indicator for one of the following three classifications: J = major; M= minor; B = bypass. This indicator is used to sort the claims into the following groups: single majors, multiple majors, single minors, multiple minors, and non-OPPS claims. This indicator is based on status indicator and is discussed in greater detail in the preamble text and claims accounting.

SERVICE-DATE-OFFSET: The number of days from the actual claim-from-date. The actual claim-from-date 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.

SERVICE-REV-PAYMENT: The computed total 2021 OPPS payment for a line item, including deductible, coinsurance, and program payment.