

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

**FILE DESCRIPTION**

This file contains select claim level data and is derived from 2003 hospital outpatient PPS claims, updated through December 2003. That is, claims for services furnished on or after January 1, 2003, through December 31, 2003 that were received, processed, and paid by December, 2003. This file includes more than 52 million claims, for services paid under the OPPS, including observation, multiple and single claims. This is a flat file available on cartridges. The record length is 9973, blocksize is 32760.

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

**FILE LAYOUT**

XR00@DBT0992.NPR5.OPPSBEF1.T0040601

**FILE NAMES**

01 FIELD NAME	FORMAT	POSITION
03 PROVIDER-NUMBER	PIC X(6).	1- 6
03 BILL-TYPE	PIC X(2).	7- 8
03 FROM-DATE	PIC S9(5)COMP-3.	9- 11
03 PRINCIPAL-DIAGNOSIS	PIC X(5).	12- 16
03 OTHER-DIAGNOSES	PIC X(45).	17- 61
03 OUTLIER-PAYMENT	PIC S9(9)V99 COMP-3.	62- 67
03 SERVICE-LINE-COUNT	PIC S9(3) COMP-3.	68- 69
03 SERVICE-LINE	OCCURS 0 TO 300 TIMES DEPENDING ON SERVICE-LINE-COUNT	70-9969
05 SERVICE-REVENUE-CODE	PIC X(4).	
05 SERVICE-HCPCS	PIC X(5).	
05 SERVICE-DATE-OFFSET	PIC S9(3)COMP-3.	
05 SERVICE-UNIT-COUNT	PIC S9(7)COMP-3.	
05 SERVICE-TOTAL-CHARGE S	PIC S9(9)V99 COMP-3.	
05 SERVICE-COST	PIC S9(9)V99 COMP-3.	
05 SERVICE-REV-PAYMENT	PIC S9(9)V99 COMP-3.	

**CLAIM AND SERVICE LINE FIELD DEFINITIONS:**

**CLAIM FIELD DEFINITIONS**

PROVIDER-NUMBER: The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

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

PRINCIPAL-DIAGNOSIS: The ICD-9-CM diagnosis code 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.

OTHER-DIAGNOSES: The ICD-9-CM code identifying the beneficiary's other diagnosis. This field can include up to nine ICD9 codes.

OUTLIER-PAYMENT: 2002 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). 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

SERVICE-REV-PAYMENT: The computed 2002 OPPS payment for a line item based on the payment APC. The "payment APC" refers to total payment, including deductible, coinsurance, and program payment.