Limited Data Set (LDS) for Partial Hospitalization Program and Intensive Outpatient 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 2022 claims for partial hospitalization program (PHP) services and non-PHP OPPS hospital claims for similar services furnished on or after January 1, 2022 through December 31, 2022. The non-PHP OPPS claims included in this file are identified as Intensive Outpatient Program (IOP) claims by the "PUF-TYPE" field in this file. Please refer to the CY 2024 OPPS/ASC final rule and the CY 2024 OPPS claims accounting for a full discussion of the trims and exclusions applied to the PHP and non-PHP OPPS claims included in this file and the methodology used for modeling costs for days with 3 and 4 or more services. The file contains claims with dates of service January 1, 2022 through December 31, 2022 that were received, processed, and passed to the National Claims History file by June 30, 2023. This file includes 606,737 claims for PHP and non-PHP claims for 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.FN24.PHPIOPLD. T0231016

FILE LAYOUT

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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.
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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 hospital based PHP (HPHP), hospital based IOP (HIOP) or PHP community mental health center (CMHC). These claim types are defined as:

> HPHP: Records for partial hospitalization program (PHP) services furnished by hospitals, n= 13,418
> HIOP: Records for intensive outpatient program (IOP) services furnished by hospitals (non-PHP hospital claims with a least 1 PHP/IOP HCPCS code), n= 590,045
> CMHC: Records for partial hospitalization program (PHP) services furnished by community mental health centers (CMHCs), n=3,274

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 2022 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 total 2022 OPPS payment for a line item, including deductible, coinsurance, and program payment.