CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 45 **Date: DECEMBER 19, 2003**

CHANGE REQUEST 2994

I. SUMMARY OF CHANGES: Update to Outpatient Provider (OPROV) Specific File

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 20, 2004
***IMPLEMENTATION DATE: January 20, 2004**

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

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

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 45	Date: December 19, 2003	Change Request 2994

SUBJECT: Update to Outpatient Provider (OPROV) Specific File

I. GENERAL INFORMATION

A. Background: The Outpatient Provider (OPROV) Specific File contains required information about each provider to enable the pricing software to calculate the payment amount. Fiscal intermediaries (FIs) must maintain the accuracy of the data, and update the files as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio.

B. Policy: N/A

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
Ch 4, Sec 50.1 Requirement #1	FIs shall maintain the accuracy of the data of the Outpatient Provider (OPROV) Specific File.	FIs
Ch 4, Sec 50.1 Requirement #2	FIs shall update the Outpatient Provider (OPROV) Specific File as changes occur in data element values.	FIs
Ch 4, Sec 50.1 Requirement #3	FIs shall furnish CMS a quarterly file in the same format.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 20, 2004 **Implementation Date: January 20, 2004** **Pre-Implementation Contact(s): Joe Bryson 410-786-2986 or jbryson2@cms.hhs.gov** **Post-Implementation Contact(s): Appropriate Regional Office**	**These instructions should be implemented within your current operating budget.**

50.1 - Outpatient Provider Specific File

(Rev. 45, 12-19-03)

A-02-026

The outpatient provider (OPROV) specific file contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and format are shown below. FIs 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. 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.

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

File Position	Format	Title	Description
1-8	X(8)	National Provider Identifier (NPI)	Alpha-numeric 8 character provider number
9-10	X(2)	NPI Filler	Blank
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 OPPS period. For subsequent OPPS 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. Date file created/run date of the PROV report for submittal to CO
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. (Termination date is the date on which the reporting intermediary ceased servicing the provider in question).
49	X	Waiver Indicator	"N" means not waived (under OPPS) and "Y" means waived (not under OPPS).
50-54	9(5)	Intermediary Number	Intermediary #
55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter the appropriate code (must be blank or 00, 02-08, 13-18, 21-23, or 32-38): 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric

			04 Rehabilitation Facility *05 Pediatric* *06 Hospital Distinct Parts* *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* *38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998*
57	*X*	*Filler*	*Blank*
58	*X*	*Change Code For Wage Index Reclassification*	*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.*
59-62	*X(4)*	*Actual Geographic Location—MSA*	*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.*
63-66	*X(4)*	*Wage Index Location—MSA*	*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.*
67-70	*9V9(3)*	*Payment-to-Cost Ratio*	*Enter the provider's payment-to-cost ratio.*
71-75	*9(5)*	*Bed Size*	*Indicate the number of adult hospital beds and pediatric beds available.*
76-79	*9V9(3)*	*Outpatient Cost-to-Charge Ratio*	*Derived from the latest available cost report data.*
80-96	*X(17)*	*Filler*	*Blank*
97-100	*9(4)*	*Reduced*	*Enter the number of APCs the provider has*

		Coinsurance Trailer Count	*elected to reduce coinsurance for. The number cannot be greater than 999.*

The FI enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than *9*99.

Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to systems 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).*