

HEALTHCARE COST AND UTILIZATION PROJECT — HCUP
A FEDERAL-STATE-INDUSTRY PARTNERSHIP IN HEALTH DATA
Sponsored by the Agency for Healthcare Research and Quality

INTRODUCTION TO
THE HCUP NATIONWIDE AMBULATORY SURGERY SAMPLE (NASS)
2022

**These pages provide only an introduction to the 2022 NASS.
For full documentation and notification of changes,
visit the HCUP User Support (HCUP-US) website at
www.hcup-us.ahrq.gov.**

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HCUP NATIONWIDE AMBULATORY SURGERY SAMPLE (NASS) SUMMARY OF DATA USE RESTRICTIONS

***** REMINDER *****

All users of the NASS must take the online HCUP Data Use Agreement (DUA) training course, and read and sign a Data Use Agreement. Details and links may be found on the following page.

Authorized users of HCUP data agree to the following restrictions:^a

- Will not use the data for any purpose other than research, analysis, and aggregate statistical reporting.
- Will not re-release any data to unauthorized users.
- Will not redistribute HCUP data by posting on any website or publishing in any other publicly accessible online repository. Will cite restrictions on data sharing in the Data Use Agreement and direct them to AHRQ HCUP (www.hcup-us.ahrq.gov) for more information on accessing HCUP data if a journal or publication requests access to data or analytic files.
- Will not identify or attempt to identify any individual, including by the use of vulnerability analysis or penetration testing. Methods that could be used to identify individuals directly or indirectly shall not be disclosed or published.
- Will not report any statistics where the number of observations (i.e., individual discharge records) in any given cell of tabulated data is less than or equal to 10 (≤ 10).
- Will not publish information that could identify individual establishments (e.g., hospitals) and will not contact establishments.
- Will not use the data concerning individual establishments for commercial or competitive purposes affecting establishments, or to determine rights, benefits, or privileges of establishments.
- Will not use the data for criminal and civil litigation, including expert witness testimony or for law enforcement activities.
- Will not use data elements from the proprietary severity adjustment software packages (e.g., 3M™ APR-DRGs) for any commercial purpose or to disassemble, decompile, or otherwise reverse engineer the proprietary software.
- Will acknowledge in reports that data from the “Healthcare Cost and Utilization Project (HCUP)” were used, including names of the specific databases used for analysis.^b

Any violation of the limitations in the Data Use Agreement is punishable under Federal law by a fine, up to five years in prison, or both. Violations may also be subject to penalties under State statutes.

^a This is a summary of key terms of the Data Use Agreement for Nationwide Databases; please refer to the DUA for full terms and conditions.

^b Suggested citations for the HCUP databases are provided in the Requirements for Publishing with HCUP Data available at www.hcup-us.ahrq.gov/db/publishing.jsp.

HCUP DATA USE AGREEMENT REQUIREMENTS

All Healthcare Cost and Utilization Project (HCUP) data users, including data purchasers and collaborators, must complete the online HCUP Data Use Agreement (DUA) Training Course and read and sign the HCUP DUA. Proof of training completion and signed DUAs must be submitted to the HCUP Central Distributor.

Data purchasers will be required to provide their DUA training completion code and will execute their DUAs electronically as a part of the online ordering process. The DUAs and training certificates for collaborators and others with access to HCUP data should be submitted directly to the HCUP Central Distributor using the contact information below.

The online DUA Training Course is available at www.hcup-us.ahrq.gov/tech_assist/dua.jsp.

The HCUP Nationwide DUA is available on the HCUP User Support (HCUP-US) website at <https://hcup-us.ahrq.gov/team/NationwideDUA.pdf>.

HCUP CONTACT INFORMATION

HCUP Central Distributor and HCUP User Support

Information about the content of the HCUP databases is available on the HCUP User Support (HCUP-US) website (www.hcup-us.ahrq.gov).

If you have questions, please review the HCUP Frequently Asked Questions located at www.hcup-us.ahrq.gov/tech_assist/faq.jsp.

If you need further technical assistance, please contact the HCUP Central Distributor and User Support team at:

Phone: (866) 290-HCUP (4287) (toll free)

Email: hcup@ahrq.gov

Fax: (866) 551-4587

We would like to receive your feedback on the HCUP data products. Please send user feedback to hcup@ahrq.gov.

WHAT IS THE NATIONWIDE AMBULATORY SURGERY SAMPLE (NASS)?

- The Nationwide Ambulatory Surgery Sample (NASS) is a calendar-year, encounter-level database of selected therapeutic ambulatory surgeries constructed from the Healthcare Cost and Utilization Project (HCUP) State Ambulatory Surgery and Services Databases (SASD).
- The ambulatory surgeries selected for inclusion in the NASS are therapeutic procedures which require the use of an operating room, penetrate or break the skin, and involve regional anesthesia, general anesthesia, or sedation to control pain. Procedures intended primarily for diagnostic purposes were excluded. To be considered in-scope for the NASS, ambulatory surgeries are also required to have a relatively high annual volume or aggregate total facility charge. Examples include ambulatory surgeries such as cataract surgery, cholecystectomy, appendectomy, gastric bypass, hysterectomy, hernia repair, spinal fusion, and hip replacement. See [Appendix B](#) for a complete list of in-scope ambulatory surgeries.
- The NASS is the only all-payer ambulatory surgery database, yielding national and regional estimates of in-scope ambulatory surgery encounters performed in hospital-owned facilities. The NASS contains clinical and resource-use information that is included in a typical hospital-owned facility record, including patient characteristics, clinical diagnostic and surgical procedure codes, disposition of patients, total charges, expected source of payment, and facility characteristics.
- The 33 States that contribute data to the 2022 NASS (see [Appendix A, Table A.1](#)) are geographically dispersed and account for 80.6 percent of the total U.S. resident population, an estimated 64.9 percent sample of the universe of hospital-owned facilities performing ambulatory surgeries, and an estimated 73.5 percent sample of the universe of ambulatory surgery encounters.
- Unweighted, the NASS contains approximately 9.1 million in-scope ambulatory surgery encounters in 2022, corresponding to approximately 12.1 million in-scope ambulatory surgeries (some encounters have more than one in-scope ambulatory surgery). Weighted, it estimates approximately 12.4 million in-scope ambulatory surgery encounters and 16.4 million in-scope ambulatory surgeries in the United States, 2022.
- The NASS is a publicly available database that can be purchased through the HCUP Central Distributor. Currently, the NASS is available for data years 2016–2022.
- Users must complete the HCUP Data Use Agreement Training Course before receiving the data.

WHAT'S NEW IN THE 2022 NATIONWIDE AMBULATORY SURGERY SAMPLE (NASS) AND LOAD PROGRAMS?

- The total number of in-scope ambulatory surgery encounters for data year 2022 increased by 4 percent from 11.9 million in 2021 to 12.4 million.
- The number of diagnoses increased from 25 to 30 to retain all diagnoses on at least 99 percent of all encounters.
- Changes to the procedures considered in scope for the NASS sample can change from year to year. In addition, there were some NASS design changes between 2016–2019 that will cause some discontinuity in multi-year analyses. See Section 4.8 for more information about how this affects trending estimates over time.

UNDERSTANDING THE NATIONWIDE AMBULATORY SURGERY SAMPLE (NASS)

- This document, *Introduction to the HCUP Nationwide Ambulatory Surgery Sample (NASS) 2022*, summarizes the content of the NASS and describes the development of the NASS sample and weights.
- Important considerations for data analysis are highlighted, and references to further resources are provided.
- In-depth documentation for the NASS is available on the HCUP User Support (HCUP-US) website (www.hcup-us.ahrq.gov). Please refer to detailed documentation before using the data.

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HCUP Nationwide Ambulatory Surgery Sample (NASS)

ABSTRACT

The Nationwide Ambulatory Surgery Sample (NASS) is part of the Healthcare Cost and Utilization Project (HCUP), which is sponsored by the Agency for Healthcare Research and Quality (AHRQ).

The NASS was created to enable analyses of selected ambulatory surgery utilization patterns and to support public health professionals, administrators, policymakers, and clinicians in their decision making regarding this critical source of care. The NASS contains clinical and resource-use information that is included in a typical hospital-owned facility record abstract, including patient characteristics, clinical diagnostic and surgical procedure codes, disposition of patients, total charges, expected source of payment, and facility characteristics.

The NASS is the largest all-payer ambulatory surgery database that has been constructed in the United States, yielding national estimates of selected therapeutic ambulatory surgery encounters performed in hospital-owned facilities. The ambulatory surgeries selected for inclusion in the NASS are therapeutic procedures which require the use of an operating room, penetrate or break the skin, and involve regional anesthesia, general anesthesia, or sedation to control pain. To be considered in-scope for the NASS, ambulatory surgeries are also required to have a relatively high annual volume or aggregate total facility charge. Examples include ambulatory surgeries such as cataract surgery, appendectomy, gastric bypass, hysterectomy, hernia repair, spinal fusion, and hip replacement.

The 2022 NASS contains information from 9.1 million ambulatory surgery encounters at 2,799 hospital-owned facilities that approximate an estimated 64.9 percent stratified sample of U.S. hospital-owned facilities performing ambulatory surgeries. Weights are provided to estimate national total 12.4 million ambulatory surgery encounters in 2022.

The NASS is drawn from statewide data organizations that provide HCUP with data from ambulatory surgery encounters. Thirty-three HCUP Partner organizations participated in the 2022 NASS ([Appendix A, Table A.1](#)).

By stratifying on important facility characteristics, the NASS is designed to be representative of U.S. hospital-owned facilities that perform ambulatory surgeries. Post-stratification for the purposes of weighting is based on the following characteristics: geographic region (Northeast, Midwest, South, and West), hospital bed size (small, medium, and large dependent on region, location, and teaching status), urban-rural location of the hospital (metropolitan and nonmetropolitan), hospital teaching status, and hospital ownership or control (public, for profit, and not for profit)

Access to the NASS is open to users who sign Data Use Agreements. Uses are limited to research and aggregate statistical reporting.

For more information on the NASS, visit the AHRQ-sponsored HCUP User Support (HCUP-US) website at www.hcup-us.ahrq.gov/db/nation/nass/nassdbdocumentation.jsp.

INTRODUCTION TO THE NATIONWIDE AMBULATORY SURGERY SAMPLE (NASS)

1 OVERVIEW OF NASS DATA

The Healthcare Cost and Utilization Project (HCUP) Nationwide Ambulatory Surgery Sample (NASS) was created to enable analysis of selected ambulatory surgery utilization patterns and to support public health professionals, administrators, policymakers, and clinicians in their decision making regarding this critical source of care. The NASS has many research, policy, and other data-driven applications because it contains clinical and nonclinical information about in-scope ambulatory surgeries and diagnoses as well as geographic, facility, and patient characteristics.

1.1 NASS Data Sources, Hospitals, and Encounters

The 2022 NASS is sampled from the HCUP [State Ambulatory Surgery and Services Databases \(SASD\)](#). The SASD include various types of outpatient services, such as observation stays, lithotripsy, radiation therapy, imaging, chemotherapy, and labor and delivery. The specific types of ambulatory surgeries and outpatient services included in each SASD vary by State and data year. All SASD include data on ambulatory surgery encounters from hospital-owned facilities. Some States include data from nonhospital-owned facilities, although these are not included in the NASS.¹ The SASD do *not* include ambulatory surgery encounters that were subsequently admitted to the same hospital for inpatient care. As such, the NASS does not contain any encounters admitted to the inpatient setting from the ambulatory setting. Information on patients admitted to the hospital following ambulatory surgery is included in the HCUP State Inpatient Databases (SID).

The sampling of the NASS changed over time to capture emergent in-scope ambulatory surgeries (i.e., in-scope “narrow” surgeries that were started in the emergency department):

- Starting with data year 2020, the NASS was sampled only from the SASD because records for emergent in-scope ambulatory surgeries were included in the SASD.
- In data year 2019, the NASS was sampled from the SASD *and* [State Emergency Department Databases \(SEDD\)](#) because records for emergent in-scope ambulatory surgeries were only included in the SEDD (and not in the SASD).
- In the 2016–2018 NASS, these emergent ambulatory surgeries were undercounted because the NASS was sampled from the SASD without these types of ambulatory surgeries. The procedures most impacted by this issue included appendectomy and removal of ectopic pregnancy (each undercounted by more than 50%) and cholecystectomy (undercounted by approximately 10%).

The number of States, hospital-owned facilities, and ambulatory surgery encounters in the NASS varies by year (Table 1).

¹ The following States have data for nonhospital-owned facilities in at least one year of the HCUP SASD: California, Florida, Illinois, Kentucky, Michigan, Missouri, North Carolina, New York, Oklahoma, Oregon, Pennsylvania, South Carolina, Utah, and Wisconsin.

Table 1. Number of States, Hospital-Owned Facilities, and Encounters in the NASS by Year

Data Year	States in the NASS	Number of Hospital-Owned Facilities	Number of AS Encounters, Unweighted	Number of AS Encounters, Weighted for National Estimates
2022	AK, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NY, OH, OR, PA, SC, SD, TN, TX, UT, VT, WI (OK not included)	2,799	9,097,088	12,380,477
2021	AK, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, WI	2,881	8,896,507	11,916,522
2020	AK, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, WI	2,899	7,828,310	10,337,699
2019	AK, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, WI	2,958	8,994,101	11,880,487
2018	CA, CO, CT, DC, FL, GA, IA, IL, IN, KS, KY, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, VT, WI (HI and UT data were not available)	2,699	7,693,084	10,696,131
2017	CA, CO, CT, DC, FL, GA, IA, IL, IN, KS, KY, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, WI (HI data were not available)	2,737	7,647,636	10,570,649
2016	CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, WI	2,751	7,608,879	10,623,113

Abbreviations: AS, Ambulatory Surgery; NASS, Nationwide Ambulatory Surgery Sample.

The 2022 NASS sample comprises data from 33 HCUP Partner organizations (32 States and the District of Columbia). [Appendix A, Figure A.1](#) represents the geographic distribution of the HCUP Partner organizations that contributed to the 2022 NASS. The HCUP NASS States with the District of Columbia account for 80.6 percent of the U.S. population in 2022, an estimated 64.9 percent of hospital-owned facilities performing ambulatory surgeries, and an estimated 73.5 percent of ambulatory surgery encounters. Details on the percentage of population, encounters, and facilities by region are provided in [Appendix A, Table A.4](#) and [Appendix A, Table A.5](#).

The NASS is limited to encounters with at least one in-scope ambulatory surgery on the record, performed at hospital-owned facilities. *In-scope ambulatory surgeries* are defined based on the following factors:

- Surgical procedure: a therapeutic procedure that would require the use of an operating room, penetrate or break the skin, and involve regional anesthesia, general anesthesia, or sedation to control pain. These surgeries are identified by Healthcare Common Procedure Coding System (HCPCS) Level I codes, commonly referred to as Current Procedural Terminology (CPT®) codes on the billing record, and are categorized as *narrow* in the HCUP Surgery Flag Software.² The term narrow is specific to the Surgery Flag Software. Starting with v2019.2 of the HCUP Surgery Flag Software (used for the 2018–2019 NASS), narrow surgeries are identified in the following ranges of CPT codes: surgical, emerging technology, radiology, and medical (excluding the evaluation and management codes). Prior to that radiology and medical CPTs were not included in the HCUP Surgery Flag Software. For the 2022 NASS, v2022.1 of the HCUP Surgery Flag Software (which includes the same types of procedures as v2019.2) was used because v2022.1 is relevant to CPT codes valid in calendar year 2022.
- Frequency: Surgeries, categorized by groups of CPT codes in the Clinical Classifications Software for Services and Procedures (CCS-Services and Procedures),³ with a relatively high volume or aggregate total facility charge, and evidence of reliable reporting from SASD hospitals. Detailed in-scope ambulatory surgery selection criteria are outlined in [Section 3.2](#). A complete list of 2022 in-scope CCS-Services and Procedures categories is included in [Appendix B](#). The 2022 sample includes 2,799 hospitals, 9,097,088 in-scope ambulatory surgery encounters (unweighted), and 12,380,477 in-scope ambulatory surgery encounters (weighted for national estimates).

Although encounters are limited to those with at least one in-scope ambulatory surgery on the record, the NASS Supplemental File provides information on other surgical and nonsurgical procedures performed during these encounters (see [Section 1.3](#)).

1.2 Data Restrictions

Some HCUP Partner organizations that contributed data to the NASS imposed restrictions on the release of certain data elements. In addition, because of confidentiality laws, some data sources were prohibited from providing HCUP with encounter records that indicated specific medical conditions, such as HIV/AIDS or behavioral health conditions. Detailed information on these restrictions is available in [Appendix C](#).

² Agency for Healthcare Research and Quality. Surgery Flag Software for Services and Procedures. Healthcare Cost and Utilization Project (HCUP). Released May 26, 2021. https://hcup-us.ahrq.gov/toolssoftware/surgeryflags_svcproc/surgeryflagssvc_proc.jsp. Accessed December 27, 2023. For more information, reference the Surgery Flag Software for Services and Procedures User Guide, available at: www.hcup-us.ahrq.gov/toolssoftware/surgeryflags_svcproc/surgeryflagssvc_proc.jsp#user.

³ The Clinical Classifications Software for Services and Procedures (CCS-Services and Procedures) is HCUP software that provides a method for classifying CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes into clinically meaningful procedure categories. More than 9,000 CPT/HCPCS codes and 6,000 HCPCS codes are collapsed into 244 clinically meaningful categories that may be more useful for presenting descriptive statistics than are individual CPT or HCPCS codes. For more information, visit www.hcup-us.ahrq.gov/toolssoftware/ccs_svcsproc/ccssvcproc.jsp.

1.3 File Structure of the NASS

The NASS is delivered as a set of related files. A hospital file lists hospitals in the NASS along with hospital attributes (e.g., teaching status, bed size category) as well as the encounter weight and post-stratification stratum information. An encounter file links to the hospital table and contains information on the selected ambulatory surgery encounter (e.g., patient age, expected source of payment, diagnoses), including information about in-scope ambulatory surgeries. A related supplemental file contains entries for out-of-scope procedures with a key linking to the encounter file. Finally, a diagnosis and procedure group file contains information about diagnosis groupings with a key linking to the encounter file. (Note that this file is not available in the 2016 or 2017 NASS.)

Hospital File: This hospital-level file contains one observation for each hospital included in the NASS, along with encounter weight and select hospital characteristics. For 2022, the NASS Hospital File has 2,799 hospital-specific records. A list of data elements in the Hospital File is provided in [Appendix D, Table D.1](#).

Encounter File: This encounter-level file contains 100 percent of ambulatory surgery encounters containing an in-scope ambulatory surgery from hospital-owned facilities in participating States and the District of Columbia that meet facility inclusion criteria. For 2022, the NASS Encounter File has about 9.1 million ambulatory surgery encounter records (unweighted). Refer to [Appendix D, Table D.2](#) for a list of data elements in the NASS Encounter File.

Supplemental File: This encounter-level file contains information on procedures that were performed during encounters recorded in the Encounter File but not considered to be in-scope ambulatory surgeries in the NASS. The Supplemental File contains about 6.9 million records for 2022. This file includes less records than the Encounter File because not all encounters included both in-scope and not-in-scope procedures. If an encounter had no not-in-scope procedures, then there is no record in the Supplemental File. Procedures included on the Supplemental File are limited to CPT procedure codes. HCPCS Level II codes were excluded from the Supplemental File. Refer to [Appendix D, Table D.3](#) for a list of data elements in the NASS Supplemental File.

Diagnosis and Procedure Groups File: Available beginning with the 2020 NASS, this encounter-level file contains information about International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis groups and comorbidity measures for all diagnoses associated with encounters recorded in the Encounter File, derived from the Clinical Classifications Software Refined (CCSR) for ICD-10-CM Tool⁴ and Elixhauser Comorbidity Software Refined for ICD-10-CM.⁵ Refer to [Appendix D, Table D.4](#) for a list of data elements in the NASS Diagnosis and Procedure Groups File.

1.4 NASS Data Elements

The coding of data elements in the NASS is consistent with the coding in other HCUP databases. The following three objectives guided the definition of data elements in all HCUP databases:

⁴ Clinical Classifications Software Refined (CCSR). Healthcare Cost and Utilization Project (HCUP). October 2021. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp. Accessed September 22, 2022.

⁵ Elixhauser Comorbidity Software Refined for ICD-10-CM Healthcare Cost and Utilization Project (HCUP). October 2021. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/toolssoftware/comorbidityicd10/comorbidity_icd10.jsp. Accessed September 22, 2022.

- Ensure usability without extensive editing by analysts
- Retain the largest amount of information available from the original sources, while still maintaining consistency among sources
- Structure the information for efficient storage, manipulation, and analysis

More information on the coding of HCUP data elements is available on the HCUP User Support (HCUP-US) website (www.hcup-us.ahrq.gov/db/coding.jsp).

After analyzing the availability of information from the HCUP Partner organizations, a set of common fields to be available in the NASS was created. The NASS contains more than 100 clinical and nonclinical variables, such as the following:

- Patient demographics (e.g., sex, age, race and ethnicity, urban-rural designation of residence, national quartile of the median household annual income for the patient's ZIP Code)
- HCPCS Level I, also known as CPT procedure codes
- ICD-10-CM diagnosis codes
- Total charges and expected payment source (e.g., Medicare, Medicaid, private insurance, self-pay)
- Hospital characteristics (e.g., ownership, teaching status, region of the United States)

For comprehensive information about the NASS data elements, please refer to the NASS documentation on the HCUP-US website (www.hcup-us.ahrq.gov/db/nation/nass/nassdbdocumentation.jsp).

2 GETTING STARTED

The HCUP NASS is distributed as comma-separated value (CSV) files delivered via secure digital download from the [Online HCUP Central Distributor](#). The files are compressed and encrypted with 7-Zip®.

The NASS product is downloaded in a single zipped file, which contains several data-related files and accompanying documentation. The four data-related files include the following compressed files:

- 1) Hospital File (NASS_2022_Hospital.zip)
- 2) Encounter File (NASS_2022_Encounter.zip)
- 3) Supplemental File (NASS_2022_Supplemental.zip)
- 4) Diagnosis and Procedure Groups File (NASS_2022_DX_PR_GRPS.zip)

To load and analyze the NASS data on a computer, users will need the following:

- The password provided by the HCUP Central Distributor
- A hard drive with *at least* 80 gigabytes (GB) of space available
- A third-party zip utility such as 7-Zip®, ZIP Reader, SecureZIP®, WinZip®, or Stuffit Expander®
- SAS®, SPSS®, Stata®, or similar analysis software

The total size of the CSV version of the 2022 NASS is approximately 14 GB. The NASS files loaded into SAS are about 22 GB. Most SAS data steps will require twice the storage space of the file so that the input and output files can coexist.

With a file of this size, space easily could become a problem in a multistep program. It is not unusual to have several versions of a file marking different steps while preparing it for analysis, and there may be more versions for the actual analyses. Therefore, users should plan carefully because the amount of space required could escalate rapidly.

2.1 Decompressing the NASS Files

To extract the data files from the compressed download file, follow these steps:

- 1) Create a directory for the NASS on your hard drive.
- 2) Unzip the compressed NASS product file into the new directory using a third-party zip utility. This will place three compressed, encrypted data-related files in the new directory. You will be prompted to enter the encryption password (sent separately by email) to decrypt the file.

Please note that attempts to unzip encrypted files using the built-in zip utility in Windows® (Windows Explorer) or Macintosh® (Archive Utility) will produce an error message warning of an incorrect password and/or file or folder errors. The solution is to use a third-party zip utility.

Third-party zip utilities are available from the following reputable vendors on their official websites:

- 7-Zip® (Windows) (free download offered by 7-Zip)
 - ZIP Reader (Windows) (free download offered by the PKWARE corporation)
 - SecureZIP for Mac or Windows (free evaluation and licensed/fee software offered by the PKWARE corporation)
 - WinZip (Windows) (evaluation and fee versions offered by the WinZip corporation)
 - Stuffit Expander (Mac) (free evaluation and licensed/fee software offered by Smith Micro corporation)
- 3) Unzip each of the compressed, encrypted data-related files using the same password and third-party zip utility method. This will place the data-related CSV files in the same directory by default.

2.2 Downloading and Running the Load Programs

Programs to load the data into SAS, SPSS, or Stata are available on the HCUP-US website. To download and run the load programs, follow these steps:

- 1) Go to the NASS Database Documentation page on HCUP-US at www.hcup-us.ahrq.gov/db/nation/nass/nassdbdocumentation.jsp.
- 2) Go to the “File Specifications and Load Programs” section on this page.
- 3) Click on “Nationwide SAS Load Programs,” “Nationwide SPSS Load Programs,” or “Nationwide Stata Load Programs” to go to the corresponding Load Programs page.
- 4) Select the data year and the database (“NASS”) from the drop-down lists on this page.

- 5) Select and save the load programs you need. **The load programs are specific to the data year and data-related file.** Save the load programs into the same directory as the NASS CSV files on your computer.
- 6) Edit and run the load programs as appropriate for your computing environment to create the analysis files. For example, modify the directory paths to point to the location of your input and output files.

NOTE: Prior to the 2020 NASS, the Encounter File and Supplemental File load programs use the same variable names for the array of CPT codes (e.g., CPT1) and their associated CCS-Services and Procedures categories (e.g., CCSCPT1). When merging the Encounter and Supplemental Files, this can result in CPT and CCS-Services and Procedures codes being overwritten unintentionally in one file or the other. Starting with the 2020 NASS, the Supplemental File load program uses the variable names SupCPT n and SupCPTCCS n , where n indicates the order in the CPT array.

2.3 NASS Documentation

Comprehensive documentation for the NASS files is available on the HCUP-US website (www.hcup-us.ahrq.gov/db/nation/nass/nassdbdocumentation.jsp). Users of the NASS can access complete file documentation, including variable notes, file layouts, summary statistics, and related technical reports. Similarly, data users can download SAS, SPSS, and Stata load programs. These important resources help the user understand the structure and content of the NASS and aid in using the database. [Appendix A, Table A.2](#) details the comprehensive NASS documentation available on HCUP-US.

2.4 HCUP Online Tutorials

For additional assistance, the Agency for Healthcare Research and Quality (AHRQ) has created the HCUP Online Tutorial Series, a series of free, interactive courses that provide information on using HCUP data and tools and training on technical methods for conducting research with HCUP data. Topics include an [HCUP Overview Course](#) and these tutorials:

- The [Load and Check HCUP Data](#) tutorial provides instructions on how to unzip (decompress) HCUP data, save it on your computer, and load the data into a standard statistical software package. This tutorial also describes how to verify that the data have loaded correctly.
- The [HCUP Sample Design](#) tutorial is designed to help users learn how to account for sample design in their work with the HCUP nationwide databases. The tutorial will be updated in the future to directly address the NASS sampling design.
- The [Producing National HCUP Estimates](#) tutorial is designed to help users understand how three of the nationwide databases—the National (Nationwide) (NIS), the Nationwide Emergency Department Sample (NEDS), and the Kids' Inpatient Database (KID)—can be used to produce national and regional estimates. A tutorial specific to the NASS database will be added in the future.
- The [Calculating Standard Errors](#) tutorial shows how to accurately determine the precision of the estimates produced from the HCUP nationwide databases. Users will learn two methods for calculating standard errors for estimates produced from the HCUP nationwide databases.
- The [HCUP Software Tools Tutorial](#) introduces users to the HCUP software tools, which can be applied to HCUP and other administrative databases to create new data elements from existing data, thereby enhancing a researcher's ability to conduct

analyses. There are four modules within this course grouping the HCUP tools by the following coding systems: ICD-10-CM diagnoses, ICD-10-PCS procedures, CPT and HCPCS Level II codes, and ICD-9-CM diagnoses and procedures. Users will learn about the purpose of each tool and receive technical guidance for applying the tools to their data.

Other tutorials about the design or use of the HCUP databases are also available, and new tutorials are added periodically. The Online Tutorial Series is located on the HCUP-US website at www.hcup-us.ahrq.gov/tech_assist/tutorials.jsp.

3 METHODS

3.1 Creation of the NASS

Creation of the NASS requires the following steps:

- *Identify in-scope ambulatory surgeries.* The HCUP Surgery Flag Software (see [Section 3.2](#)) is used to identify **in-scope ambulatory surgeries**. The ambulatory surgeries selected for inclusion in the NASS are therapeutic procedures which require the use of an operating room, penetrate or break the skin, and involve regional anesthesia, general anesthesia, or sedation to control pain. Additional empirical criteria are used to define qualifying CCS-Services and Procedures⁶ categories or **in-scope ambulatory surgeries**. Selection criteria for a given CCS-Services and Procedures category include meeting volume or charge thresholds (i.e., the surgery accounts for at least .05% of total in-scope ambulatory surgery volume in the SASD **or** at least .05% of total charges associated with in-scope ambulatory surgery encounters in the SASD) and evidence that SASD hospitals are reliably reporting in-scope ambulatory surgeries in the CCS-Services and Procedures category.
- *Build the NASS hospital sampling frame.* The NASS sampling frame is limited to facilities owned by community hospitals (excluding rehabilitation and long-term acute care hospitals) in the SASD that perform in-scope ambulatory surgeries. Additional restrictions imposed for the NASS sampling frame were that the hospitals have no gross irregularities in quarterly reporting volume, submit data to the SASD in all four quarters of the data year, and not have an unusually low volume of encounters containing an in-scope ambulatory surgery. (For the 2020 NASS, only quarters 1, 3, and 4 were used to judge irregularities in quarterly volume because almost all facilities had a severe drop in surgeries in quarter 2 of 2020 because of the COVID-19 pandemic.)
- *Build encounter predictive models.* NASS sampling frame hospitals are used to create models for volumes of encounters containing in-scope ambulatory surgeries. The predictive model can be applied to hospitals outside the NASS sampling frame.
- *Construct the universe of hospitals and ambulatory surgery encounters.* A national list of all hospitals performing ambulatory surgeries is created using the SASD and hospitals reporting outpatient surgery volume in the American Hospital Association (AHA) Annual Survey of Hospitals™. (Prior to data year 2019, the Centers for Medicare & Medicaid Services (CMS) Provider of Services (POS) file was also used.) The encounter

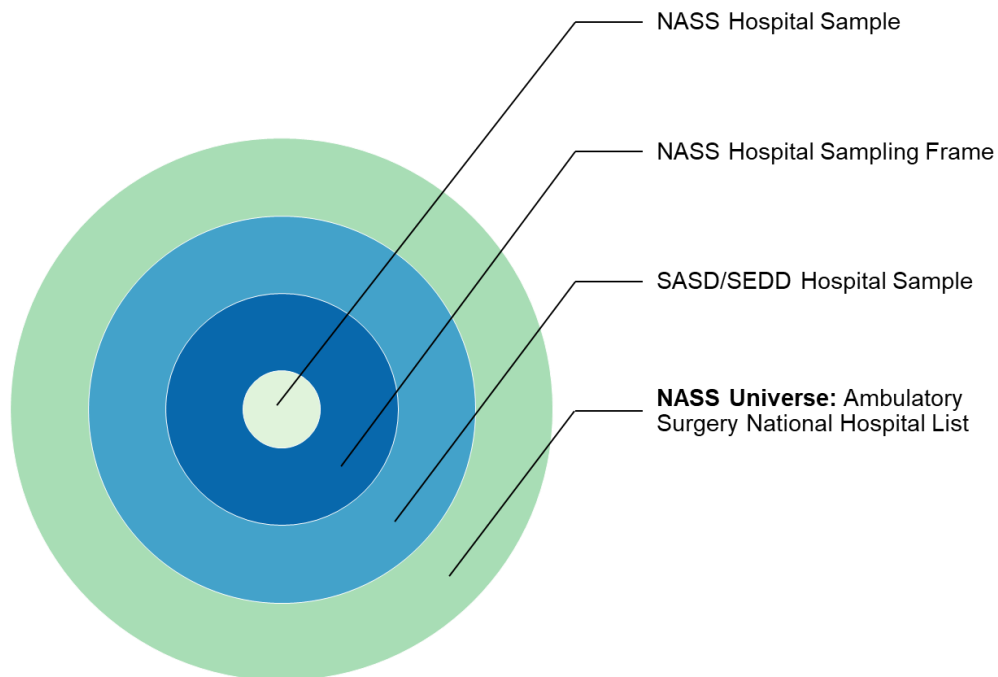
⁶ Agency for Healthcare Research and Quality. Clinical Classifications Software (CCS) for Services and Procedures. Healthcare Cost and Utilization Project (HCUP). Last modified May 26, 2021. www.hcup-us.ahrq.gov/toolssoftware/ccs_svcsproc/ccssvcproc.jsp. Accessed September 22, 2022.

predictive model is applied to hospitals outside the NASS sampling frame and then combined with observed data from sampling frame hospitals to create national encounter volume estimates.

- *Develop NASS sample strata.* Strata are created using hospital characteristics. When needed, strata are collapsed to achieve reasonable hospital sample/universe ratios. At least 10 hospitals are required in each stratum.
- *Compute sample weights.* Hospitals performing in-scope procedures are sampled from the NASS sampling frame. On the basis of the set of NASS sample hospitals and universe totals, sample weights that project the NASS encounters and in-scope ambulatory surgeries to the universe are computed.
- *Create the NASS database.* All of the previous steps culminate in a NASS database, which is a set of four related files: Hospital, Encounter, Supplemental, and Diagnosis and Procedure Groups.

The relationship between the NASS universe, the SASD sample, and the NASS sampling frame is portrayed in Figure 1. The predictive model for hospital ambulatory surgery encounter volume is developed using the NASS sampling frame hospitals and then is applied to all other hospitals not in the sampling frame to generate the encounter universe. In 2022, the NASS sample and sampling frame were identical because 100 percent of hospitals were sampled.

Figure 1. NASS Hospital Universe, SASD Sample, and NASS Sampling Frame



Abbreviations: NASS, Nationwide Ambulatory Surgery Sample; SASD, State Ambulatory Surgery and Services Databases.

The following sections describe several of the NASS development steps in greater detail.

3.2 Selection of In-Scope Ambulatory Surgeries

3.2.1 Definition of In-Scope Ambulatory Surgery

HCUP Surgery Flag Software⁷ was used to identify surgical procedures of interest for the NASS. The Surgery Flag Software classifies CPT procedure codes as *narrow*, *broad*, or *neither*. The NASS focuses on surgeries in the *narrow* class, or **in-scope ambulatory surgeries**. These surgeries consist of procedures that (1) require the use of an operating room, (2) penetrate or break the skin, and (3) involve regional anesthesia, general anesthesia, or sedation to control pain. Examples of in-scope procedures include cataract surgery, cholecystectomy, appendectomy, gastric bypass, hysterectomy, hernia repair, spinal fusion, and hip replacement. The following three procedures, which are primarily performed for a diagnostic purpose, are assigned a *narrow* surgery flag based on the degree of their invasiveness: biopsies if the procedure is within an internal organ (e.g., brain, deep cervical node, stomach), thoracotomy with or without biopsy, and exploratory laparotomy with or without biopsy.

Starting with v2019.2 of the HCUP Surgery Flag Software (used for the 2018–2019 NASS), *narrow* surgeries are identified in the following ranges of CPT codes: surgical, emerging technology, radiology, and medical (excluding the evaluation and management codes). Prior to that, radiology and medical CPTs were not included in the HCUP Surgery Flag Software. For the 2022 NASS, v2022.1 of the HCUP Surgery Flag Software (which includes the same types of procedures as v2019.2) was used because v2022.1 is relevant to CPT codes valid in calendar year 2022.

3.2.2 Selection of In-Scope Ambulatory Surgeries

Several selection criteria were used to define **in-scope ambulatory surgeries** for the NASS. Prior to application of selection criteria, all in-scope ambulatory surgeries identified by HCUP Surgery Flag Software (as *narrow*) were grouped in categories defined by CCS for Services and Procedures.⁸ For the 2022 NASS, v2022.1 of the CCS for Services and Procedures was used because it is relevant to CPT codes valid in calendar year 2022.

Beginning with data year 2019, the following criteria were applied at the CCS-Services and Procedures category level:

1. *Volume and charges*. The ambulatory surgery accounts for at least .05% of total ambulatory surgery volume in the SASD **or** at least .05% of total charges associated with ambulatory surgery encounters in the SASD.
2. *Reporting quality*. Hospitals are reliably submitting ambulatory surgery data. Four CCS-Services and Procedures categories are excluded because an examination of the data in the SASD showed evidence of unreliable reporting or underreporting of dental services, skin grafts, wound debridement, and percutaneous transluminal coronary angioplasty (PTCA)⁹ at the hospital-level.

⁷ Agency for Healthcare Research and Quality. Surgery Flag Software for Services and Procedures. Healthcare Cost and Utilization Project (HCUP). http://www.hcup-us.ahrq.gov/toolsoftware/surgeryflags_svcproc/surgeryflagssvc_proc.jsp. Accessed November 11, 2024.

⁸ Agency for Healthcare Research and Quality. Clinical Classifications Software (CCS) for Services and Procedures. Healthcare Cost and Utilization Project (HCUP). www.hcup-us.ahrq.gov/toolsoftware/ccs_svcsproc/ccssvcproc.jsp. Accessed November 11, 2024.

⁹ Percutaneous transluminal coronary angioplasty (PTCA) was included in earlier years of the NASS (2016 and 2017).

The final set of included, or *in-scope*, CCS-Services and Procedures categories for the 2022 NASS is provided in [Appendix B](#). [Appendix B](#) also includes a running list of changes to the in-scope procedure groups over time.

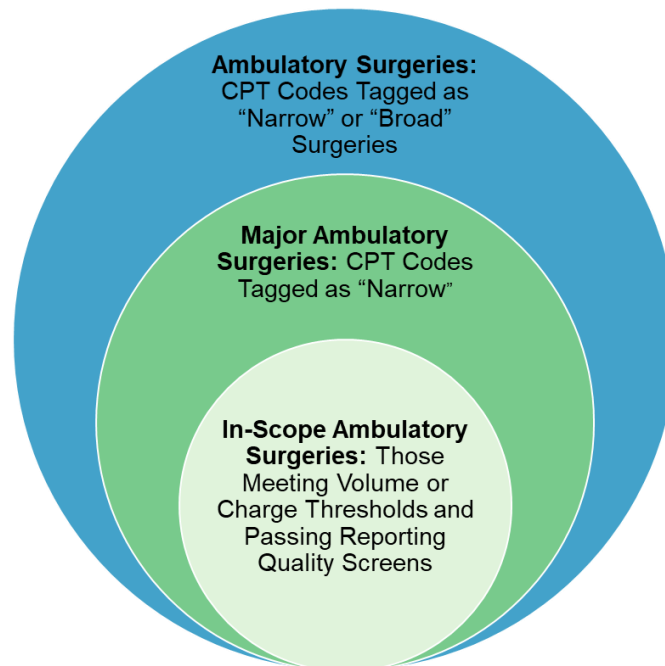
Prior to data year 2019, the following criteria were applied at the CCS-Services and Procedures category level:

1. *Hospital share*. A substantial share of in-scope ambulatory surgeries occurs in hospital-owned facilities (at least 25 percent of in-scope ambulatory surgeries for the CCS-Services and Procedures category)
2. *Volume*. A relatively high in-scope ambulatory surgery volume is observed in the SASD (4,000 surgeries annually).
3. *Reporting quality*. Hospitals are reliably submitting ambulatory surgery data.

Figure 2 illustrates the relationship between ambulatory surgeries, major ambulatory surgeries, and in-scope ambulatory surgeries.

Note that although encounters are limited to those with at least one in-scope ambulatory surgery on the record, the NASS Supplemental File provides information on other (or *out-of-scope*) procedures performed during these encounters.

Figure 2. Ambulatory Surgeries, Major Ambulatory Surgeries, and In-Scope Ambulatory Surgeries



Abbreviation: CPT, Current Procedural Terminology.

3.3 Sampling Design of the NASS

The NASS is a stratified cluster sample of in-scope ambulatory surgery encounters ([see Section 3.2](#)) occurring in hospital-owned facilities. The main objective of a stratified sample is to ensure that it is representative of the target universe with respect to factors in the stratification scheme. In this section, we summarize the NASS setting and universe definition, the process for constructing the sampling frame, the sample strata, the sampling plan, and the calculation of sample weights.

3.3.1 Ambulatory Surgery Setting and Universe Definition

Ambulatory surgeries can be performed in hospital-owned facilities, nonhospital-owned ambulatory surgery centers (ASCs), or office settings. In this context, *office* means a place of service that is neither a hospital-owned facility nor an ASC. The office setting may include professional facilities with procedure rooms or surgical suites.

HCUP Partners provide information on ambulatory surgeries in hospital-owned facilities. About half of the Partners also provide ambulatory surgery data from facilities that are not hospital owned. The designation of a facility as *hospital owned* is specific to its financial relationship with a hospital that provides inpatient care and is not related to its physical location. Hospital-owned ambulatory surgery and other outpatient care facilities may be contained within the hospital, physically attached to the hospital, or located in a different geographic area. The designation as *hospital owned* means that HCUP can verify that the hospital is billing for this service.

The NASS is restricted to in-scope ambulatory surgeries performed in the hospital-owned facilities, either in the hospital itself or in physically separate hospital-owned facilities. There are two reasons for this restriction. First, the SASD have more than twice as many hospital-owned facilities as facilities that are not hospital owned. Second, although the HCUP hospital sampling frame is well understood, much less is known about the HCUP sample of surgery facilities that are not hospital owned compared with all freestanding ASCs.

In addition to restricting attention to the hospital-owned facilities, facilities are limited to U.S. community hospitals, defined as “all non-Federal, short-term, general, and other specialty hospitals, excluding hospital units of institutions.”¹⁰ Noncommunity hospitals are excluded because of inconsistent capture of data across HCUP States. Additionally, community hospitals that are either rehabilitation or long-term acute care (LTAC) facilities are excluded because these hospitals treat a unique patient population that has longer stays and higher costs.

A key challenge for the NASS design is the creation of national in-scope ambulatory surgery encounter volume estimates (*encounter universe*), tabulated in strata used in the sampling design. National estimates do not exist for several reasons, but the most important is the definition of *ambulatory surgery* itself. Organizations collecting survey information from hospitals, such as the AHA, rely on verbal descriptions of ambulatory surgery.¹¹ These descriptions leave room for interpretation and result in significant variation in which encounters

¹⁰ See the AHA “community hospital designation” at www.ahadataviewer.com/glossary.

¹¹ The AHA Annual Survey definition for *outpatient surgery* is as follows: Scheduled surgical services provided to patients who do not remain in the hospital overnight. The surgery may be performed in operating suites also used for inpatient surgery, specially designated surgical suites for outpatient surgery, or procedure rooms within an outpatient care facility. (American Hospital Association. 2021 AHA Annual Survey. https://www.ahadata.com/system/files/media/file/2022/11/AHA-Annual-Survey-2021_0.pdf. Accessed January 31, 2024.)

hospitals report as ambulatory surgeries. In contrast, hospitals generally report total inpatient admissions, births, and emergency department visits with reasonable accuracy.

The NASS uses a CPT code- and data-based definition of **in-scope ambulatory surgeries** (see [Section 3.2](#)). Self-reported hospital ambulatory surgery volumes from the AHA may or may not be consistent with the HCUP definition of *in-scope ambulatory surgeries*, and it is challenging to ascertain that consistency. Consequently, rather than using an external reference source for in-scope ambulatory surgery volumes, the NASS universe of in-scope ambulatory surgery encounters was constructed by combining observed encounter volumes for hospitals in the NASS sampling frame and estimated encounter volumes for all other hospitals performing in-scope ambulatory surgeries. Estimated encounter volumes were generated using a predictive model, described in [Section 3.4.1](#).

3.3.2 Generating the Ambulatory Surgery National Hospital List

A crucial step in developing the NASS was generating a list of hospitals performing in-scope ambulatory surgery outside the NASS sampling frame and hospital-specific predictor variables to compute estimated encounters using a predictive model (see [Section 3.4.1](#)).

Hospitals were included in the national list if they were a community hospital. Rehabilitation and LTAC hospitals were excluded. Hospitals reporting no outpatient surgeries in the AHA Annual Survey were then excluded from the national list.

Model predictor variables were obtained from the AHA Annual Survey (for HCUP SASD hospitals and hospitals reporting outpatient surgeries in the AHA Annual Survey). See Table 2 for a description of the predictor variables obtained from AHA.

3.4 NASS Sampling Frame

Selection of SASD hospitals for the NASS sampling frame was limited to facilities owned by community hospitals, excluding rehabilitation and LTAC hospitals.¹²

Additional restrictions imposed for the NASS sampling frame were that the hospital (1) have no gross irregularities in quarterly reporting volume, (2) submit data to the SASD in all four quarters of the year, and (3) not have an unusually low volume of encounters containing an in-scope ambulatory surgery.

A comparison between the NASS hospital universe and the final NASS sample is provided in [Appendix A, Table A.3](#).

3.4.1 NASS Encounter Predictive Model

Creation of the in-scope ambulatory surgery encounter universe requires a method for estimating the volume of encounters containing in-scope ambulatory surgeries for hospitals outside the NASS sampling frame. This estimation was accomplished by building a predictive model for encounters using data from hospitals in the NASS sampling frame.

The hospital-specific number of encounters containing at least one in-scope ambulatory surgery

¹² The HCUP SASD contain a number of hospital-owned facilities performing major ambulatory surgeries that are not inpatient hospitals. In the NASS, these facilities are assigned the identifier of the hospital owner. Stratification, sampling, weighting, and reporting are performed using the hospital owner identifier and hospital characteristics.

was the outcome variable in the model. A model predicting the number of in-scope ambulatory surgery encounters per hospital was developed using the NASS sampling frame hospitals. Predictor variables used in the model are reported in Table 2.

Table 2. Independent Variables Included in Encounter Predictive Model

Category	Independent Variable
Ownership	Voluntary, not for profit
	Proprietary, for profit
	Local or State government
Location and teaching status	Rural location
	Urban nonteaching
	Urban teaching
Census region	Midwest
	Northeast
	South
	West
Hospital size (number of beds)	001–025
	026–049
	050–099
	100–199
	200–299
	300–399
	400–499
	500+
AHA Annual Survey: self-reported outpatient surgery volume	Log scale

Abbreviation: AHA, American Hospital Association.

3.4.2 Post-Stratification for Weighting

Post-stratification for the purpose of weighting allows for compensation of any over- or under-represented types of hospitals in the NASS sampling frame with respect to the distribution in the target universe. Hospital characteristics for post-stratification were selected using results from the encounter predictive model (which quantifies the importance of stratification factors in encounter volume variation) and a study of the current NIS and NEDS stratification schemes. Table 3 contains values for the NASS stratification variables: census region, bed size category,¹³ location and teaching status, and ownership.¹⁴ There are over 100 possible strata (i.e., unique combinations of region, bed size, location/teaching status, and ownership categories).

¹³ Bed size categories were originally established for the development of the 1998 Nationwide Inpatient Sample (NIS). Cutoff points were chosen so that approximately one-third of the hospitals in each region, location, and teaching status combination would fall within each bed size category (small, medium, or large). For more information, reference the *Introduction to the NIS*, available at www.hcup-us.ahrq.gov/db/nation/nis/nisdbdocumentation.jsp.

¹⁴ Hospital service type was not used as a stratum because of its weaker predictive power in the predictive models and the small number of children’s hospitals in the sample.

Table 3. NASS Stratification Variables

Stratum	Code	Label
Census region	1	North
	2	Midwest
	3	South
	4	West
Bed size category	1	Small (depends on region, location, and teaching status)
	2	Medium (depends on region, location, and teaching status)
	3	Large (depends on region, location, and teaching status)
Location and teaching status	1	Rural
	2	Urban nonteaching
	3	Urban teaching
Ownership	1	Local and State government
	2	Voluntary, not for profit
	3	Proprietary, for profit

Abbreviation: NASS, Nationwide Ambulatory Surgery Sample.

A goal was established to have at least 10 hospitals assigned to each stratum with as many strata as possible having a sampling fraction greater than 0.20.¹⁵

Assignment of hospitals to the initial stratification scheme of over 100 levels results in a number of strata with fewer than 10 sampling frame hospitals and small sampling fractions. In those cases, ownership category was collapsed, first by combining local and State government with voluntary hospitals.¹⁶ If the goal still was not achieved, all the ownership types were combined.

After the initial strata collapsing was completed, additional adjustments were made to ensure no single stratum had a large percentage of total encounter or hospital volume. This led to relaxing the number of sampling frame hospitals or sampling fraction criteria for some strata. Following these additional adjustments, the NASS had 57 strata for 2022. In the end, all strata had at least 10 hospitals and sampling fractions greater than 0.20.

3.5 Encounter Weights

To obtain nationwide estimates, encounter weights were developed combining the NASS universe of hospitals and encounters with the NASS sample hospitals and encounters.

Computation of encounter weights is straightforward. Given a universe of encounter volumes in stratum s , the encounter weight is computed as the ratio of NASS universe to sample encounter volumes so that the sample volume is inflated to agree with the universe volume within the stratum.

¹⁵ The *sampling fraction* is defined as (number units in sample)/(number units in universe). The overall sampling fraction for the 2022 universe of hospitals and sampling frame is $(2,799/4,314) = 0.73$.

¹⁶ The ownership category was chosen for collapsing because it had lower explanatory power in the predictive models than did bed size or location and teaching status. Census region was considered as an essential stratum to include in the design.

3.5.1 Frame Sampling Rate

For the 2022 NASS, all hospitals in the sampling frame were selected for inclusion in the NASS, resulting in an approximate 64.9 percent sample of universe hospitals.

3.5.2 Encounter Weights

Encounter weights were calculated by stratum. Within stratum s for hospital i , the universe weight for each encounter in the NASS sample was calculated as follows:

$$W_{is}(\text{universe}) = [N_s(\text{universe}) \div N_s(\text{sample})] \times (4 \div Q_i),$$

where $W_{is}(\text{universe})$ is the encounter weight, $N_s(\text{universe})$ represents the number of ambulatory surgery encounters in the universe within stratum s , $N_s(\text{sample})$ is the number of ambulatory surgery encounters from sample hospitals selected for the NASS, and Q_i represents the number of quarters of ambulatory surgery encounters contributed by hospital i to the NASS ($Q_i = 4$ for all hospitals). Thus, each encounter's weight is equal to the number of universe ambulatory surgery encounters it represents in stratum s during that year. $W_{is}(\text{universe})$ is named DISCWT in the NASS encounter table ([see Appendix D, Table D.2](#)). The NASS sampling frame required that all hospitals qualifying for the frame submit data in all four quarters of the year, with the exception of data year 2020 in which quarter 2 (April-June) was not counted because of the emergence of COVID-19.

4 HOW TO USE THE NASS FOR DATA ANALYSIS

This section provides a synopsis of special considerations for using the NASS.

4.1 Calculating National Estimates

To produce national estimates, weights MUST be used.

The in-scope ambulatory surgery encounter weight (DISCWT) in the NASS Encounter Table should be used for producing nationwide, encounter-level statistics where the ambulatory surgery encounter is the unit of analysis.

Because the NASS is a stratified cluster sample, proper statistical techniques must be used to calculate standard errors and confidence intervals. For detailed instructions, refer to the HCUP Methods Series report #2003-02, [Calculating Nationwide Inpatient Sample \(NIS\) Variances for Data Years 2011 and Earlier](#), on the HCUP-US website (www.hcup-us.ahrq.gov). The HCUP NIS prior to 2012 used a stratified sampling design similar to the NASS, so techniques appropriate for the NIS prior to 2012 also are appropriate for the NASS.

4.2 Choosing Data Elements for Analysis

For all data elements to be used in the analysis, the analyst first should perform descriptive statistics and examine the range of values, including the number of missing cases. When anomalies (such as large numbers of missing cases) are detected, descriptive statistics can be computed by region for that variable to determine whether there are region-specific differences. Sometimes, computing descriptive statistics by hospital can be helpful in detecting hospital-specific data anomalies.

4.3 ICD-10-CM Diagnosis Codes and CPT Procedure Codes

Each unique analysis should consider limitations related to ICD-10-CM and CPT procedure codes.

- CPT procedure codes, which are copyrighted by the American Medical Association, can change each year in January. It is essential to check all procedure codes used for analysis to ensure that the codes are in effect during the time period(s) studied.
- ICD-10-CM diagnosis codes provide valuable insights into the reasons for hospitalization and what procedures patients receive, but these codes need to be carefully used and interpreted. ICD-10-CM codes change every October as new codes are introduced and some codes are retired. It is critical to check all ICD-10-CM codes used for analysis to ensure that the codes are in effect during the time period studied.
- The NASS contains fields for up to 30 in-scope CPT-coded procedures, and up to 30 out-of-scope CPT-coded procedures, although the number of code fields populated varies by State because of reporting differences. Some States provide more than the maximum code fields retained on the NASS. To reduce the file size of the NASS, the number of codes retained was limited.
- The number of diagnosis fields included in the NASS has varied over time: up to 30 diagnoses in 2022, up to 25 diagnoses in the 2021, up to 20 diagnoses in the 2020, and up to 15 diagnoses from 2016–2019. The number of code fields populated also varies by State because of reporting differences. Some States provide more than the maximum code fields retained on the NASS. To reduce the file size of the NASS, the number of codes retained was limited to retain all codes on at least 99.9 percent of all encounters.

4.4 Missing Values

Missing data values can compromise the quality of estimates. For example, if the outcome for ambulatory surgery encounters with missing values is different from the outcome for ambulatory surgery encounters with valid values, then sample estimates for that outcome will be biased and inaccurately represent the ambulatory surgery utilization patterns. Several techniques are available to help overcome this bias. One strategy is to use imputation to replace missing values with acceptable values. Another strategy is to use sample weight adjustments to compensate for missing values. Descriptions of such data preparation and adjustment are outside the scope of this report; however, it is recommended that researchers evaluate and adjust for missing data, if necessary.

Alternatively, if the cases with and without missing values are assumed to be similar with respect to their outcomes, no adjustment may be necessary for estimates of means and rates because the nonmissing cases would be representative of the missing cases. However, some adjustment still may be necessary for the estimates of totals. Sums of data elements (such as aggregate ambulatory surgery charges) containing missing values would be incomplete because cases with missing values would be omitted from the calculations. Estimates of the sum of charges should use the product of the number of cases times the average charge to account for records with missing information.

4.5 Variance Calculations

It may be important for researchers to calculate a measure of precision for some estimates based on the NASS sample data. Variance estimates must account for both the sampling design and the form of the statistic. The NASS sampling design consists of a stratified, single-stage cluster sample. A stratified random sample of hospitals (clusters) providing in-scope ambulatory surgeries was drawn, and then all encounters with in-scope ambulatory surgeries were included from each selected hospital. **To accurately calculate variances from the NASS, appropriate statistical software and techniques must be used.** For detailed instructions, refer to the HCUP Methods Series report #2003-02, [Calculating Nationwide](#)

[Inpatient Sample \(NIS\) Variances for Data Years 2011 and Earlier](http://www.hcup-us.ahrq.gov/), on the HCUP-US website (www.hcup-us.ahrq.gov/). The HCUP NIS prior to 2012 used a stratified sample design similar to the NASS, so techniques appropriate for the NIS prior to 2012 also are appropriate for the NASS.

If hospitals inside the sampling frame are like hospitals outside the frame, the sample hospitals can be treated as if they were randomly selected from the entire universe of hospitals within each stratum. Standard formulas for a stratified, single-stage cluster sample without replacement could be used to calculate statistics and their variances in most applications.

A multitude of statistics can be estimated from the NASS data. Several computer programs that calculate statistics and their variances from sample survey data are listed in [Section 4.6](#). Some of these programs use general methods of variance calculations (e.g., the jackknife and balanced half-sample replications) that account for the sampling design. However, it may be desirable to calculate variances using formulas specifically developed for certain statistics.

These variance calculations are based on finite-sample theory, which is an appropriate method for obtaining cross-sectional, nationwide estimates of outcomes. According to finite-sample theory, the intent of the estimation process is to obtain estimates that are precise representations of the nationwide population at a specific point in time. In the context of the NASS, any estimates that attempt to accurately describe characteristics and interrelationships among hospitals and ambulatory surgery encounters during a specific year should be governed by finite-sample theory. Examples include estimates of expenditure and utilization patterns.

Alternatively, in the study of hypothetical population outcomes not limited to a specific point in time, the concept of a *superpopulation* may be useful. Analysts may be less interested in specific characteristics of the finite population (and time period) from which the *sample* was drawn than they are in hypothetical characteristics of a conceptual superpopulation from which any particular finite *population* in a given year might have been drawn. According to this superpopulation model, the nationwide population in a given year is only a snapshot in time of the possible interrelationships among hospital, market, discharge, encounter, or visit characteristics. In a given year, all possible interactions between such characteristics may not have been observed, but analysts may wish to predict or simulate interrelationships that may occur in the future.

Under the finite-population model, the variances of estimates approach zero as the sampling fraction approaches one. This is the case because the population is defined at that point in time and because the estimate is for a characteristic as it existed when sampled. This is in contrast to the superpopulation model, which adopts a stochastic viewpoint rather than a deterministic viewpoint. That is, the nationwide population in a particular year is viewed as a random sample of some underlying superpopulation over time. Different methods are used for calculating variances under the two sample theories. The choice of an appropriate method for calculating variances for nationwide estimates depends on the type of measure and the intent of the estimation process.

4.6 Computer Software for Weighted and Variance Calculations

Computer programs are readily available to perform weighted variance calculations. Several statistical programming packages allow weighted analyses.¹⁷ For example, nearly all SAS procedures incorporate weights. In addition, several statistical analysis programs have been developed to specifically calculate statistics and their standard errors from survey data. Version 8 or later of SAS contains procedures (PROC SURVEYMEANS and PROC SURVEYREG) for calculating statistics on the basis of specific sampling designs. Stata and SUDAAN[®] are two other common statistical software packages that perform calculations for numerous statistics arising from the stratified, single-stage cluster sampling design. Examples of the use of SAS, SUDAAN, and Stata to calculate NIS variances are presented in the special report [Calculating Nationwide Inpatient Sample \(NIS\) Variances for Data Years 2011 and Earlier](#) on the HCUP-US website (www.hcup-us.ahrq.gov). For a helpful review of programs to calculate statistics from survey data, visit the following website: www.hcp.med.harvard.edu/statistics/survey-soft/.

The NASS includes a Hospital File with variables required by these programs to calculate finite-population statistics. The file includes synthetic hospital identifiers (Primary Sampling Units, or PSUs), stratification variables, and stratum-specific totals for the numbers of ambulatory surgery encounters and hospitals so that finite-population corrections can be applied to variance estimates.

In addition to these subroutines, standard errors can be estimated by validation and cross-validation techniques. Depending on the analysis problem, a large number of observations may be available, and it may be feasible to set aside a part of the data for validation purposes. Standard errors and confidence intervals then can be calculated from the validation data.

If the analytic file is too small to set aside a large validation sample, cross-validation techniques may be used. For example, tenfold cross-validation would split the data into 10 subsets of equal size. The estimation would take place in 10 iterations. In each iteration, the outcome of interest is predicted for one-tenth of the observations by an estimate based on a model that is fit to the other nine-tenths of the observations. Unbiased estimates of error variance then are obtained by comparing the actual values to the predicted values obtained in this manner.

4.7 Limitations of the NASS

The NASS contains about 9 million ambulatory surgery encounter records and many clinical and nonclinical data elements. Many research studies can be conducted with the data, but some limitations should be considered:

The NASS contains *encounter*-level records, not *patient*-level records. This means that individual patients who visit a hospital facility for ambulatory surgery multiple times in 1 year may be present in the NASS multiple times. No uniform patient identifier is available that would allow a patient-level analysis to identify individuals with more than one ambulatory surgery encounter or to track outcomes or additional follow-up care received after an encounter. In contrast, some HCUP State databases may be used for this type of analysis.

The database includes only CPT codes. HCPCS Level II codes are excluded.

¹⁷ Carlson BL, Johnson AE, Cohen SB. An evaluation of the use of personal computers for variance estimation with complex survey data. *J Off Statistics*. 1993;9(4):795-814.

Beginning with the 2021 NASS, the data element HOSP_TEACH, which indicates teaching status of hospitals, was excluded from the Hospital File to protect identities of hospitals located in rural areas. The data element HOSP_LOCTEACH, which remains on the file, can be used to identify teaching hospitals in urban areas. Beginning with data year 2020, the data element HOSP_CONTROL, which indicates the type of hospital ownership, was excluded from the Hospital File to protect identities of hospitals.

4.8 Considerations for Trending Over Time

When conducting longitudinal analyses, users should exercise caution and consider several aspects of the NASS design and changes to the design over time.

- **Procedures considered in scope for the NASS sample can change from year to year (see [Appendix B](#)).** These changes may result from an increase or decrease in the volume of procedures performed in the outpatient setting, as this determines whether a CCS category meets the threshold for inclusion in the NASS sample. Additionally, the 2018 NASS applied updated versions of the HCUP Surgery Flag Software for Services and Procedures (that expanded the range of possible CPT codes) and the CCS for Services and Procedures Tool. Combined, these updates contributed to changes in the CPT procedures and CCS procedure groups defined as in-scope for the NASS sample. The 2019 NASS applied revised in-scope procedure criteria, which also contributed to changes in the in-scope categories.
- **Earlier years of the NASS (2016–2018) undercount certain emergent surgeries.** Prior to data year 2019, the NASS sample was limited to SASD encounters that involved surgeries defined as “narrow” by the HCUP Surgery Flag Software for Services and Procedures. Subsequent analyses revealed additional encounters involving “narrow” or in-scope surgeries that were started in the emergency department and appeared in the State Emergency Department Databases (SEDD) but not in the SASD. As a result, these surgeries are undercounted in the 2016–2018 NASS. The procedures most impacted by this issue include appendectomy and removal of ectopic pregnancy (each undercounted by more than 50%) and cholecystectomy (undercounted by approximately 10%). In subsequent data years, these emergent in-scope surgeries are captured in the NASS.
- **The hospital-owned facility universe for the NASS changed between data years 2018 and 2019.** First, the universe was expanded to include specialty hospitals such as surgical, cancer, heart, and orthopedic facilities owned by community hospitals that performed in-scope ambulatory surgeries. This resulted in volume increases in certain surgeries commonly performed in these types of facilities. Second, the universe was limited to hospitals included in the AHA Annual Survey that reported performing outpatient surgeries. In prior years, the CMS POS data were used to augment the information.

Refer to [Appendix E](#) for a summary of CCS procedure category totals in the 2018–2022 NASS and contributing reasons for large changes over time. For the subset of CCS categories affected by NASS design changes, trend analyses based on CCS category are not recommended.

5 USER FEEDBACK AND QUESTIONS

HCUP would like to hear from data users regarding any suggestions, comments, or issues in using the NASS. Please contact HCUP User Support at hcup@ahrq.gov or (866) 290-HCUP (4287).

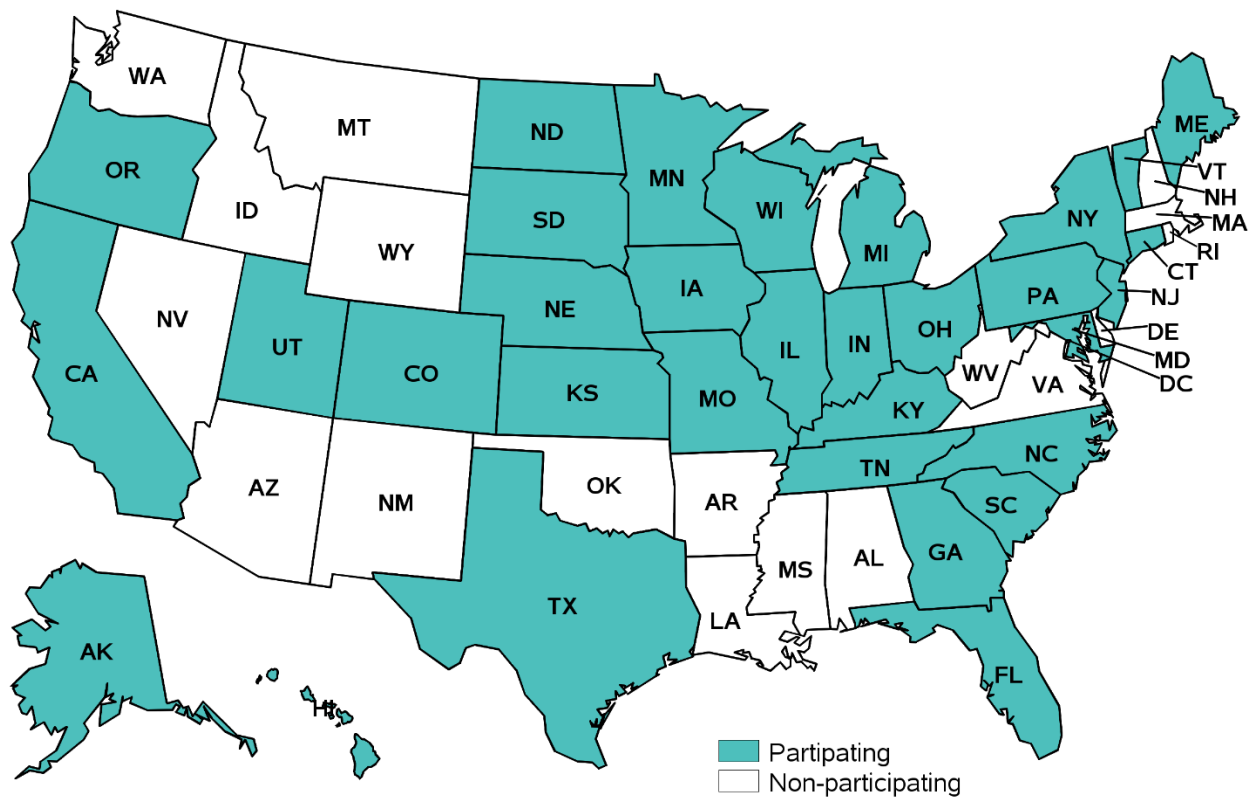
Appendix A: NASS Introductory Information

Table A.1. HCUP Partner Organizations Participating in the 2022 NASS

State	Data Organization
Alaska	Alaska Department of Health
California	California Department of Health Care Access and Information
Colorado	Colorado Hospital Association
Connecticut	Connecticut Hospital Association
District of Columbia	District of Columbia Hospital Association
Florida	Florida Agency for Health Care Administration
Georgia	Georgia Hospital Association
Hawaii	Hawaii Laulima Data Alliance
Illinois	Illinois Department of Public Health
Indiana	Indiana Hospital Association
Iowa	Iowa Hospital Association
Kansas	Kansas Hospital Association
Kentucky	Kentucky Cabinet for Health and Family Services
Maine	Maine Health Data Organization
Maryland	Maryland Health Services Cost Review Commission
Michigan	Michigan Health & Hospital Association
Minnesota	Minnesota Hospital Association
Missouri	Missouri Hospital Industry Data Institute
Nebraska	Nebraska Hospital Association
New Jersey	New Jersey Department of Health
New York	New York State Department of Health
North Carolina	North Carolina Department of Health and Human Services
North Dakota	North Dakota (data provided by the Minnesota Hospital Association)
Ohio	Ohio Hospital Association
Oregon	Oregon Association of Hospitals and Health Systems
Pennsylvania	Pennsylvania Health Care Cost Containment Council
South Carolina	South Carolina Revenue and Fiscal Affairs Office
South Dakota	South Dakota Association of Healthcare Organizations
Tennessee	Tennessee Hospital Association
Texas	Texas Department of State Health Services
Utah	Utah Department of Health
Vermont	Vermont Association of Hospitals and Health Systems
Wisconsin	Wisconsin Department of Health Services

Abbreviation: HCUP, Healthcare Cost and Utilization Project; NASS, Nationwide Ambulatory Surgery Sample.

Figure A.1. HCUP States and the District of Columbia Included in the 2022 NASS



Abbreviation: HCUP, Healthcare Cost and Utilization Project; NASS, Nationwide Ambulatory Surgery Sample.

Table A.2. NASS-Related Reports and Database Documentation Available on the HCUP-US Website

<p>Description of NASS Database</p> <ul style="list-style-type: none"> • NASS Overview <ul style="list-style-type: none"> ○ HCUP Partners in the NASS • Introduction to the NASS, 2022 (<i>this document</i>) and prior years • NASS Related Reports • Checklist for Working with the NASS <p>Restrictions on the Use</p> <ul style="list-style-type: none"> • HCUP Data Use Agreement Training • Data Use Agreement for the HCUP Nationwide Databases • Requirements for Publishing with HCUP data <p>File Specifications and Load Programs</p> <ul style="list-style-type: none"> • NASS File Specifications—details on data file names, number of records, record length, and record layout • Nationwide SAS Load Programs • Nationwide SPSS Load Programs • Nationwide Stata Load Programs <p>Data Elements</p> <ul style="list-style-type: none"> • NASS Description of Data Elements—details uniform coding and State-specific idiosyncrasies • NASS Summary Statistics—lists means and frequencies on nearly all data elements • Frequencies by Diagnosis and Procedure Codes <p>Additional Resources for NASS Data Elements</p> <ul style="list-style-type: none"> • HCUP Quality Control Procedures—describes procedures used to assess data quality • HCUP Coding Practices—describes how HCUP data elements are coded • HCUP Hospital Identifiers—explains data elements that characterize individual hospitals 	<p>NASS</p> <ul style="list-style-type: none"> • 2019 NASS Refinements • 2018 In-Scope Procedure Change <p>Known Data Issues</p> <ul style="list-style-type: none"> • 2021 <p>HCUP Tools: Labels and Formats</p> <ul style="list-style-type: none"> • Format Programs—to create value labels <ul style="list-style-type: none"> ○ HCUP Formats ○ HCUP Diagnoses and Procedure Groups Formats, including CCSR Categories ○ ICD-10-CM Formats <p>Obtaining HCUP Data</p> <ul style="list-style-type: none"> • Purchase HCUP Data from the HCUP Central Distributor
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Abbreviation: CCSR, Clinical Classification Software Refined; HCUP, Healthcare Cost and Utilization Project; ICD-10-CM/PCS, International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System; NASS, Nationwide Ambulatory Surgery Sample; US, User Support.

Table A.3. NASS Target Universe, Sampling Frame, and Final Sample Characteristics, 2022

Sample	Description	Number of Hospitals Providing Outpatient Surgery	Number of In-Scope Ambulatory Surgery Encounters
2022 target universe	Community hospitals (excluding rehabilitation and LTAC)	4,314 ^a	12,380,477 ^b
2022 NASS	Sample of target universe drawn from the sampling frame	2,799	9,097,088

Abbreviation: LTAC, long-term acute care; NASS, Nationwide Ambulatory Surgery Sample.

^a Estimated. See section 3.3.2.

^b Estimated. See section 3.4.1.

Table A.4. Percentage of Population in NASS Sample, by Census Region, 2022

Census Region	2022 Population States in NASS Sampling Frame	2022 Population States Not in NASS Sampling Frame	Total 2022 Population	States in NASS Sampling Frame: Percent of Total Population
Northeast	47,551,262	9,475,585	57,026,847	83.4
Midwest	68,783,028	0	68,783,028	100.0
South	97,562,908	31,139,122	128,702,030	75.8
West	54,674,945	24,084,561	78,759,506	69.4
Total	268,572,143	64,699,268	333,271,411	80.6

Abbreviation: NASS, Nationwide Ambulatory Surgery Sample.

Source: Annual Estimates of the Resident Population for the United States, Regions, States, the District of Columbia, and Puerto Rico: April 1, 2020 to July 1, 2023 (NST-EST2023-POP, released December 2023)., Population Division, U.S. Census Bureau, <https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-total.html>.

Table A.5. Percentage of Encounters and Facilities in NASS Sample, by Census Region, 2022

Census Region	Encounters			Facilities		
	No. of Ambulatory Surgery Encounters (Unweighted)	No. of Ambulatory Surgery Encounters (Weighted) ^a	Unweighted Encounters: Weighted Encounters, %	No. of NASS Sample Hospitals	No. of Hospitals Performing Ambulatory Surgery ^b	NASS Sample Hospitals: Hospitals Performing Ambulatory Surgery, %
Northeast	1,565,485	2,074,646	75.5	377	536	70.3
Midwest	2,988,988	3,213,160	93.0	1,082	1,304	83.0
South	3,053,563	4,687,729	65.1	879	1,588	55.4
West	1,489,052	2,404,943	61.9	461	886	52.0
Total	9,097,088	12,380,477	73.5	2,799	4,314	64.9

Abbreviations: NASS, Nationwide Ambulatory Surgery Sample.

^a Estimated. See section 3.3.2.

^b Estimated. See section 3.4.1.

**Appendix B:
2016–2022 NASS In-Scope Ambulatory
Surgeries**

Table B.1. NASS In-Scope Ambulatory Surgeries Identified by Clinical Classifications Software (CCS) for Services and Procedure Categories

CCS for Services and Procedures Category	Description	Data Years in Scope for the NASS Sample
003	Laminectomy, excision intervertebral disc	2016–2022
006	Decompression peripheral nerve	2016–2022
009	Other OR therapeutic nervous system procedures	2016–2022
010	Thyroidectomy, partial or complete	2016–2022
012	Other therapeutic endocrine procedures	2016–2022
013	Corneal transplant	2016–2022
014	Glaucoma procedures	2016–2022
015	Lens and cataract procedures	2016–2022
016	Repair of retinal tear, detachment	2016–2022
017	Destruction of lesion of retina and choroid	2019–2022
019	Other therapeutic procedures on eyelids, conjunctiva, cornea	2018–2022
020	Other intraocular therapeutic procedures	2018–2022
021	Other extraocular muscle and orbit therapeutic procedures	2016–2022
022	Tympanoplasty	2016–2022
023	Myringotomy	2016–2022
024	Mastoidectomy	2016–2022
026	Other therapeutic ear procedures	2016–2022
028	Plastic procedures on nose	2016–2022
030	Tonsillectomy and/or adenoidectomy	2016–2022
033	Other OR therapeutic procedures on nose, mouth and pharynx	2016–2022
042	Other OR therapeutic procedures on respiratory system	2016–2022
043	Heart valve procedures	2019–2022
045	Percutaneous transluminal coronary angioplasty (PTCA)	2016 and 2017 ^a
048	Insertion, revision, replacement, removal of cardiac pacemaker or cardioverter/defibrillator	2016–2022
049	Other OR heart procedures	2016–2022
053	Varicose vein stripping, lower limb	2016–2018
057	Creation, revision and removal of arteriovenous fistula or vessel-to-vessel cannula for dialysis	2016–2022
061	Other OR procedures on vessels other than head and neck	2016–2022
063	Other non-OR therapeutic cardiovascular procedures ^a	2016, 2017
067	Other therapeutic procedures, hemic and lymphatic system	2016–2022
078	Colorectal resection	2016–2022
080	Appendectomy	2016–2022
081	Hemorrhoid procedures	2018–2022
084	Cholecystectomy and common duct exploration	2016–2022
085	Inguinal and femoral hernia repair	2016–2022
086	Other hernia repair	2016–2022
087	Laparoscopy	2016–2022
094	Other OR upper GI therapeutic procedures	2016–2022
095	Other non-OR lower GI therapeutic procedures ^a	2016, 2017

CCS for Services and Procedures Category	Description	Data Years in Scope for the NASS Sample
096	Other OR lower GI therapeutic procedures	2016–2022
099	Other OR gastrointestinal therapeutic procedures	2016–2022
100	Endoscopy and endoscopic biopsy of the urinary tract	2016, 2017
101	Transurethral excision, drainage, or removal urinary obstruction	2018–2022
104	Nephrectomy, partial or complete	2018–2022
106	Genitourinary incontinence procedures	2016–2022
109	Procedures on the urethra	2016–2022
112	Other OR therapeutic procedures of urinary tract	2016–2022
113	Transurethral resection of prostate (TURP)	2016–2022
114	Open prostatectomy	2016–2022
117	Other non-OR therapeutic procedures, male genital ^a	2016, 2017
118	Other OR therapeutic procedures, male genital	2016–2022
119	Oophorectomy, unilateral and bilateral	2016–2022
120	Other operations on ovary	2016–2022
121	Ligation of fallopian tubes	2016–2022
122	Removal of ectopic pregnancy	2016–2022
124	Hysterectomy, abdominal and vaginal	2016–2022
125	Other excision of cervix and uterus	2016–2022
129	Repair of cystocele and rectocele, obliteration of vaginal vault	2016–2022
130	Other diagnostic procedures, female organs	2018
132	Other OR therapeutic procedures, female organs	2016–2022
141	Other therapeutic obstetrical procedures	2016, 2017
142	Partial excision bone	2016–2022
143	Bunionectomy or repair of toe deformities	2016–2022
144	Treatment, facial fracture or dislocation	2016–2022
145	Treatment, fracture or dislocation of radius and ulna	2016–2022
146	Treatment, fracture or dislocation of hip and femur	2017, 2019–2022
147	Treatment, fracture or dislocation of lower extremity (other than hip or femur)	2016–2022
148	Other fracture and dislocation procedure	2016–2022
149	Arthroscopy	2016–2022
150	Division of joint capsule, ligament or cartilage	2016–2022
151	Excision of semilunar cartilage of knee	2016–2022
152	Arthroplasty knee	2016–2022
153	Hip replacement, total and partial	2016–2022
154	Arthroplasty other than hip or knee	2016–2022
157	Amputation of lower extremity	2016–2022
158	Spinal fusion	2016–2022
160	Other therapeutic procedures on muscles and tendons	2016–2022
161	Other OR therapeutic procedures on bone	2016–2022
162	Other OR therapeutic procedures on joints	2016–2022
164	Other OR therapeutic procedures on musculoskeletal system	2016–2022

CCS for Services and Procedures Category	Description	Data Years in Scope for the NASS Sample
166	Lumpectomy, quadrantectomy of breast	2016–2022
167	Mastectomy	2016–2022
170	Excision of skin lesion	2019–2022
171	Suture of skin and subcutaneous tissue	2016–2017, 2019–2022
174	Other non-OR therapeutic procedures on skin and breast ^a	2016, 2017
175	Other OR therapeutic procedures on skin and breast	2016–2022
225	Conversion of cardiac rhythm	2016–2022
244	Gastric bypass and volume reduction	2016–2022

Abbreviations: GI, gastrointestinal; NASS, Nationwide Ambulatory Surgery Sample; OR, operating room.

^a CCS categories 63, 95, 117, and 174 did not meet the criteria for inclusion beginning with the 2018 NASS because all in-scope surgeries were moved from these “non-OR therapeutic procedure” categories in an update to the CCS for Services and Procedures Tool. For example, all in-scope surgeries in CCS 95, *Other non-OR lower GI therapeutic procedures* were reassigned to CCS 96, *Other OR lower GI therapeutic procedures*. Therefore, these in-scope surgeries are still included in the NASS, but with a different CCS category assignment than in previous NASS data years. CCS 45, *PTCA*, was removed from the NASS beginning with data year 2018 based on evidence of underreporting by NASS sample hospitals.

Notes: Updates to the HCUP Surgery Flag Software for Services and Procedures changed the designation of several surgeries from major (“narrow”) to not major (“broad” or “neither”), and vice versa. This affected the in-scope surgery volume and hospital-owned facility outpatient market share for multiple CCS categories, resulting in additions to and deletions from the NASS in-scope CCS procedure groups between data year 2017 and 2018. See https://hcup-us.ahrq.gov/toolsoftware/ccs_svcsproc/ccssvcproc.jsp for more information on CCS for Services and Procedures.

Appendix C: Data Restrictions

Table C.1 enumerates the types of restrictions applied to the 2022 Nationwide Ambulatory Surgery Sample. Restrictions include the following types:

- Confidentiality of hospitals
- Confidentiality of records
- Limited reporting of diagnosis codes for medical misadventures and adverse effects
- Missing encounters for specific populations of patients.

Table C.1. Data Restrictions

Confidentiality of Hospitals
<p>Limitations on release of identifiers to ensure hospital confidentiality:</p> <ul style="list-style-type: none"> • Only masked hospital identifiers are included in the NASS, allowing the identification of all ambulatory surgery encounters from a hospital. • State identifiers are not included in the NASS.
Confidentiality of Records
<p>Limitations on selected data elements to ensure patient confidentiality:</p> <ul style="list-style-type: none"> • Age (AGE) values greater than 90 are set to 90 for all NASS records. • At least one HCUP Partner required ages in years (AGE) to be set to the midpoints of age ranges. • At least one HCUP Partner requires that admission month (AMONTH) is set to missing on all records.
Limited Reporting of Diagnosis Codes for Medical Misadventures and Adverse Effects
<ul style="list-style-type: none"> • At least one HCUP Partner removes diagnosis codes for medical misadventures and adverse effects from the data files supplied to HCUP.
Missing Information for Specific Populations of Patients
<ul style="list-style-type: none"> • At least one HCUP Partner excludes records for Human Immunodeficiency Virus (HIV) patients from the files provided to HCUP. Therefore, these records are not included in the NASS. • Alternatively, at least one HCUP Partner includes records for HIV patients in the data provided to HCUP but removes the diagnosis codes identifying HIV. • At least one HCUP Partner masks the type of abortion (e.g., spontaneous, legally induced) by setting all abortion-specific diagnosis and procedure codes to “unspecified” abortions.

Abbreviations: HCUP, Healthcare Cost and Utilization Project; NASS, Nationwide Ambulatory Surgery Sample.

Appendix D: NASS Files and Data Elements

Table D.1. NASS Hospital File Data Elements, 2022

Type of Data Element	HCUP Data Element	Coding Notes
Encounter counts	TOTAL_AS_ENCOUNTERS	SASD encounters with at least one narrow surgery for this hospital ^a
	N_DISC_U	Number of ambulatory surgery encounters for <u>all</u> hospitals in the stratum
	S_DISC_U	Number of ambulatory surgery encounters for <u>sampled</u> hospitals in the stratum
Encounter weight	DISCWT	Encounter weight used to calculate national estimates
Encounter year	YEAR	Encounter year
Hospital characteristics	HOSP_BEDSIZE_CAT	Hospital bed size category: (1) 00–99, (2) 100–299, (3) 300+
	HOSP_LOCATION	Location of hospital: (0) rural, (1) urban
	HOSP_LOCTEACH	Location/teaching status of hospital: (1) rural, (2) urban nonteaching, (3) urban teaching
	HOSP_REGION	Region of hospital: (1) Northeast, (2) Midwest, (3) South, (4) West
	NASS_STRATUM	Stratum used to sample hospital-owned facilities, includes geographic region, bed size category, location/teaching status, and control/ownership
Hospital counts	N_HOSP_U	Number of hospitals in the stratum
	S_HOSP_U	Number of <u>sampled</u> hospitals in the stratum
NASS hospital identifier, synthetic	HOSP_NASS	Unique HCUP NASS hospital number, links to other NASS files, but not to other HCUP databases

Abbreviations: HCUP, Healthcare Cost and Utilization Project; NASS, Nationwide Ambulatory Surgery Sample.

^a Surgeries flagged as “narrow” in the HCUP Surgery Flag Software are defined as invasive therapeutic surgical procedures that typically require the use of an operating room and regional anesthesia, general anesthesia, or sedation.

Table D.2. NASS Encounter File Data Elements, 2022

Type of Data Element	HCUP Data Element	Coding Notes
Admission timing	AMONTH	Admission month coded from (1) January to (12) December
	AWEEKEND	Admission on weekend: (0) admission on Monday–Friday, (1) admission on Saturday–Sunday
Age at admission	AGE	Age in years coded 0–90 years. Any ages greater than 90 years were set to 90.
CPT procedure information	CPT1-CPT30	In-scope CPT procedures on the record (maximum of 30)
	CPTCCS1-CPTCCS30	Clinical Classifications Software (CCS) category for in-scope CPT procedures
	NCPT_INSCOPE	Number of in-scope CPT procedures for this encounter
Diagnosis information	I10_DX1-I10_DX30	ICD-10-CM diagnoses (maximum of 30)
	I10_NDX	Number of diagnoses for this encounter
	I10_INJURY	Injury ICD-10-CM diagnosis reported on record
	I10_MULTINJURY	Multiple ICD-10-CM injuries reported on record
Disposition of the patient	DISPUNIFORM	Disposition of patient, uniform coding: (1) routine; (2) transfer to short-term hospital; (5) other transfers, including skilled nursing facility, intermediate care, and another type of facility; (6) home healthcare; (7) against medical advice; (20) died in hospital; (99) discharged alive, destination unknown
Encounter timing	DQTR	Encounter quarter
	YEAR	Encounter year
Encounter weight	DISCWT	Encounter weight used to calculate national estimates
Hospital characteristics	NASS_STRATUM	Stratum used to sample hospital-owned facilities, includes geographic region, bed size category, location/teaching status, and control/ownership
Identifiers, synthetic	HOSP_NASS	Unique HCUP NASS hospital number, links to other NASS files but not to other HCUP databases
	KEY_NASS	Unique HCUP NASS record number, links to NASS Supplemental and Diagnosis and Procedure Groups Files, but not to other HCUP databases
National quartile for median household income of patient’s ZIP Code	ZIPINC_QRTL	Median household income quartiles for patient’s ZIP Code. For 2022, the median income quartiles are defined as (1) \$1–\$55,999, (2) \$56,000–\$70,999, (3) \$71,000–\$93,999, and (4) \$94,000 or more.
Payer information	PAY1	Expected primary payer, uniform: (1) Medicare, (2) Medicaid, (3) private including HMO, (4) self-pay, (5) no charge, (6) other

Type of Data Element	HCUP Data Element	Coding Notes
Race and ethnicity of patient	RACE	Race and ethnicity, uniform: (1) White, (2) Black, (3) Hispanic, (4) Asian or Pacific Islander, (5) Native American, (6) other
Sex of patient	FEMALE	Indicator of sex: (0) male, (1) female
Total charges	TOTCHG	Total charges for AS services, edited
Urban-rural location of patient's residence	PL_NCHS	Urban–rural designation for patient's county of residence: (1) large central metropolitan, (2) large fringe metropolitan, (3) medium metropolitan, (4) small metropolitan, (5) micropolitan, (6) not metropolitan or micropolitan

Abbreviations: AS, ambulatory surgery; CPT, Current Procedural Terminology; HCUP, Healthcare Cost and Utilization Project; HMO, health maintenance organization; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NASS, Nationwide Ambulatory Surgery Sample.

Table D.3. NASS Supplemental File Data Elements, 2022

Type of Data Element	HCUP Data Element	Coding Notes
CPT procedure information ^a	SupCPT1-SupCPT30	Out-of-scope CPT procedures on the record (maximum of 30)
	SupCPTCCS1-SupCPTCCS30	Clinical Classifications Software category for out-of-scope CPT procedures
	NCPT_NOTINSCOPE	Number of out-of-scope CPT procedures for this encounter
Encounter year	YEAR	Encounter year
Identifiers, synthetic	HOSP_NASS	Unique HCUP NASS hospital number, links to other NASS files but not to other HCUP databases
	KEY_NASS	Unique HCUP NASS record number, links to NASS Encounter and Diagnosis and Procedure Groups Files but not to other HCUP databases

Abbreviations: CPT, Current Procedural Terminology; HCUP, Healthcare Cost and Utilization Project; NASS, Nationwide Ambulatory Surgery Sample.

^a Although some encounter records may have included Level II Healthcare Common Procedure Coding System (HCPCS) codes, this procedure information is limited to Level I HCPCS codes (i.e., CPT codes).

Table D.4. NASS Diagnosis and Procedure Groups File Data Elements, 2022

Type of Data Element	HCUP Data Element	Coding Notes
CCSR for ICD-10-CM diagnoses	DXCCSR_AAAnn ¹	Indication that at least one ICD-10-CM diagnosis on the record is included in CCSR AAAnn
	DXCCSR_DEFAULT_DX1	Default CCSR for first-listed ICD-10-CM diagnosis
	DXCCSR_VERSION	Version of CCSR for ICD-10-CM diagnoses
Elixhauser Comorbidity Software Refined for ICD-10-CM	CMR_aaa ²	Comorbidity measures (aaa) identified by the AHRQ Elixhauser Comorbidity Software Refined for ICD-10-CM diagnosis codes
	CMR_VERSION	Version of the Elixhauser Comorbidity Measure Refined for ICD-10-CM
Identifiers, synthetic	HOSP_NASS	Unique HCUP NASS hospital number, links to other NASS files but not to other HCUP databases
	KEY_NASS	Unique HCUP NASS record number, links to NASS Encounter and Supplemental Files but not to other HCUP databases

Abbreviations: CCSR, Clinical Classifications Software Refined; CPT, Current Procedural Terminology; HCUP, Healthcare Cost and Utilization Project; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NASS, Nationwide Ambulatory Surgery Sample.

¹ Where AAA denotes the body system and nnn denotes the CCSR number within the body system.

² Where aaa denotes the specific comorbidity measure.

**Appendix E:
Encounter Totals by In-Scope Ambulatory
Surgeries Identified by Clinical Classifications
Software (CCS) for Services and Procedure
Category, 2019-2022**

Table E.1. Encounter Totals by In-Scope Ambulatory Surgeries Defined by Clinical Classifications Software (CCS) for Services and Procedure Category, 2019–2022

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
003	Laminectomy, excision intervertebral disc	276,727	220,940	238,730	233,377	-20.2	8.1	-2.2	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.
006	Decompression peripheral nerve	387,555	332,054	369,574	361,447	-14.3	11.3	-2.2	
009	Other OR therapeutic nervous system procedures	115,510	99,886	117,596	123,359	-13.5	17.7	4.9	
010	Thyroidectomy, partial or Complete	104,081	88,588	99,604	100,898	-14.9	12.4	1.3	
012	Other therapeutic endocrine procedures	59,067	48,429	56,957	61,409	-18	17.6	7.8	
013	Corneal transplant	20,318	15,904	18,556	18,194	-21.7	16.7	-1.9	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.
014	Glaucoma procedures	63,511	52,373	64,522	48,381	-17.5	23.2	-25.0	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19. Decrease in volume from 2021-2022 may reflect this type of procedure being performed in clinics or non-hospital owned ambulatory surgery centers not represented in the NASS.
015	Lens and cataract procedures	1,172,830	879,523	1,034,570	1,021,226	-25	17.6	-1.3	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.
016	Repair of retinal tear, detachment	99,232	85,378	94,488	91,305	-14	10.7	-3.4	

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
017	Destruction of lesion of retina and choroid	5,365	4,300	4,969	4,993	-19.8	15.6	0.5	
019	Other therapeutic procedures on eyelids, conjunctiva, cornea	152,854	113,054	132,042	133,024	-26	16.8	0.7	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.
020	Other intraocular therapeutic procedures	88,491	71,129	80,519	77,233	-19.6	13.2	-4.1	
021	Other extraocular muscle and orbit therapeutic procedures	60,624	48,741	59,810	57,314	-19.6	22.7	-4.2	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.
022	Tympanoplasty	52,013	44,158	53,261	47,864	-15.1	20.6	-10.1	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.
023	Myringotomy	335,397	181,367	173,445	290,283	-45.9	-4.4	67.4	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19. Increase in volume from 2021-2022 may reflect slow return to 2019 ambulatory surgery volume.
024	Mastoidectomy	17,616	15,331	17,315	16,835	-13	12.9	-2.8	
026	Other therapeutic ear procedures	32,892	27,796	34,505	34,576	-15.5	24.1	0.2	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.
028	Plastic procedures on nose	167,263	133,742	161,542	160,821	-20	20.8	-0.4	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19. Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.
030	Tonsillectomy and/or adenoidectomy	422,137	266,989	246,413	325,176	-36.8	-7.7	32.0	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19. Increase in volume from 2021-2022 may reflect slow return to 2019 ambulatory surgery volume.

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
033	Other OR therapeutic procedures on nose, mouth and pharynx	292,706	226,081	258,397	265,073	-22.8	14.3	2.6	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.
042	Other OR therapeutic procedures on respiratory system	35,164	30,176	37,458	37,310	-14.2	24.1	-0.4	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.
043	Heart valve procedures	4,609	3,961	4,859	4,890	-14.1	22.7	0.6	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.
048	Insertion, revision, replacement, removal of cardiac pacemaker or cardioverter/defibrillator	265,870	257,606	284,354	294,542	-3.1	10.4	3.6	
049	Other OR heart procedures	16,297	14,210	16,613	18,357	-12.8	16.9	10.5	
057	Creation, revision and removal of arteriovenous fistula or vessel-to-vessel cannula for dialysis	156,776	141,773	146,464	143,094	-9.6	3.3	-2.3	
061	Other OR procedures on vessels other than head and neck	233,450	200,379	207,269	200,669	-14.2	3.4	-3.2	

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
067	Other therapeutic procedures, hemic and lymphatic system	282,313	277,619	309,222	321,852	-1.7	11.4	4.1	
078	Colorectal resection	13,810	11,608	13,847	14,658	-15.9	19.3	5.9	
080	Appendectomy	278,430	263,929	281,913	271,070	-5.2	6.8	-3.8	
081	Hemorrhoid procedures	53,967	47,709	58,627	58,675	-11.6	22.9	0.1	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.
084	Cholecystectomy and common duct exploration	606,943	541,909	600,924	594,880	-10.7	10.9	-1.0	
085	Inguinal and femoral hernia Repair	456,556	399,740	446,198	476,637	-12.4	11.6	6.8	
086	Other hernia repair	434,222	366,704	432,328	455,299	-15.5	17.9	5.3	
087	Laparoscopy	81,420	77,524	85,695	83,237	-4.8	10.5	-2.9	
094	Other OR upper GI therapeutic procedures	26,266	21,694	24,422	26,185	-17.4	12.6	7.2	
096	Other OR lower GI therapeutic procedures	70,387	63,145	73,481	74,559	-10.3	16.4	1.5	
099	Other OR gastrointestinal therapeutic procedures	18,679	17,034	20,345	19,985	-8.8	19.4	-1.8	
101	Transurethral excision, drainage, or removal urinary obstruction	158,548	149,311	162,178	164,535	-5.8	8.6	1.5	
104	Nephrectomy, partial or complete	8,895	10,229	13,810	16,032	15.0	35.0	16.1	Increase in volume from 2020-2021 may reflect increasing use of ambulatory surgery for this type of procedure.

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
106	Genitourinary incontinence procedures	115,272	93,999	109,508	116,271	-18.5	16.5	6.2	
109	Procedures on the urethra	18,925	16,256	18,641	18,189	-14.1	14.7	-2.4	
112	Other OR therapeutic procedures of urinary tract	24,315	19,968	23,002	23,870	-17.9	15.2	3.8	
113	Transurethral resection of prostate (TURP)	89,707	79,868	91,946	97,213	-11	15.1	5.7	
114	Open prostatectomy	38,372	40,903	49,369	54,801	6.6	20.7	11.0	Increase in volume from 2020-2021 may reflect increasing use of ambulatory surgery for this type of procedure.
118	Other OR therapeutic procedures, male genital	177,839	162,850	184,628	188,540	-8.4	13.4	2.1	
119	Oophorectomy, unilateral and bilateral	184,111	163,259	190,996	221,115	-11.3	17	15.8	
120	Other operations on ovary	14,865	13,486	16,021	15,946	-9.3	18.8	-0.5	
121	Ligation of fallopian tubes	65,993	45,659	43,003	38,163	-30.8	-5.8	-11.3	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.
122	Removal of ectopic pregnancy	28,143	28,001	29,648	28,928	-0.5	5.9	-2.4	
124	Hysterectomy, abdominal and vaginal	399,826	362,270	422,864	445,052	-9.4	16.7	5.2	
125	Other excision of cervix and uterus	51,878	45,368	56,524	60,244	-12.5	24.6	6.6	Increase in volume from 2020-2021 may reflect return to 2019 ambulatory surgery volume after first year of COVID-19.

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
129	Repair of cystocele and rectocele, obliteration of vaginal vault	101,688	85,242	98,173	106,145	-16.2	15.2	8.1	
132	Other OR therapeutic procedures, female organs	236,321	204,583	242,542	252,502	-13.4	18.6	4.1	
142	Partial excision bone	277,326	233,487	240,696	228,456	-15.8	3.1	-5.1	
143	Bunionectomy or repair of toe deformities	179,157	145,009	153,165	157,304	-19.1	5.6	2.7	
144	Treatment, facial fracture or dislocation	43,810	34,101	37,987	38,249	-22.2	11.4	0.7	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.
145	Treatment, fracture or dislocation of radius and ulna	135,863	132,590	141,349	139,975	-2.4	6.6	-1.0	
146	Treatment, fracture or dislocation of hip and femur	7,355	7,812	13,741	11,291	6.2	75.9	-17.8	Increase in volume from 2020-2021 may reflect increasing use of ambulatory surgery for this type of procedure.
147	Treatment, fracture or dislocation of lower extremity (other than hip or femur)	193,280	190,041	209,312	210,257	-1.7	10.1	0.5	
148	Other fracture and dislocation Procedure	126,658	123,403	131,294	130,927	-2.6	6.4	-0.3	
149	Arthroscopy	99,699	75,626	90,568	94,628	-24.1	19.8	4.5	Decrease in volume from 2019-2020 may reflect decrease in some ambulatory surgeries during first year of COVID-19.

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
150	Division of joint capsule, ligament or cartilage	54,569	47,137	49,702	47,023	-13.6	5.4	-5.4	
151	Excision of semilunar cartilage of knee	404,838	327,348	344,790	328,294	-19.1	5.3	-4.8	
152	Arthroplasty knee	301,910	397,276	581,376	700,158	31.6	46.3	20.4	Increase in volume between 2019-2022 probably due to CMS removing total knee arthroplasty from the inpatient-only list. ^a Yearly increase in volume from 2020-2022 may reflect increasing use of ambulatory surgery for this type of procedure.
153	Hip replacement, total and Partial	49,826	207,857	339,653	405,414	317.2	63.4	19.4	Increase in 2020 probably due to Medicare allowing total hip replacements to be performed in an ambulatory surgery setting. Yearly increase in volume from 2020-2022 may reflect increasing use of ambulatory surgery for this type of procedure.
154	Arthroplasty other than hip or knee	66,148	62,708	152,901	194,937	-5.2	143.8	27.5	Yearly increase in volume from 2020-2022 may reflect increasing use of ambulatory surgery for this type of procedure.
157	Amputation of lower extremity	48,970	43,724	47,338	47,887	-10.7	8.3	1.2	
158	Spinal fusion	93,850	96,087	144,044	134,464	2.4	49.9	-6.7	Increase in volume from 2020-2021 may reflect increasing use of ambulatory surgery for this type of procedure.
160	Other therapeutic procedures on muscles and tendons	911,712	782,577	856,605	854,716	-14.2	9.5	-0.2	
161	Other OR therapeutic procedures on bone	288,187	256,529	290,005	291,941	-11	13	0.7	

CCS Category	Description	Total Encounter, N				Percentage Change, %			Potential Contributing Reasons for Change in Year-to-Year Percentage Change Greater than 20 Percent
		2019	2020	2021	2022	2019 - 2020	2020 - 2021	2021 - 2022	
162	Other OR therapeutic procedures on joints	518,568	455,452	481,878	465,008	-12.2	5.8	-3.5	
164	Other OR therapeutic procedures on musculoskeletal system	55,635	49,358	53,877	51,246	-11.3	9.2	-4.9	
166	Lumpectomy, quadrantectomy of breast	331,735	291,853	332,177	339,254	-12	13.8	2.1	
167	Mastectomy	94,411	92,734	104,353	108,980	-1.8	12.5	4.4	
170	Excision of skin lesion	134,215	107,707	122,765	128,557	-19.8	14	4.7	
171	Suture of skin and subcutaneous tissue	120,030	100,817	110,128	102,574	-16	9.2	-6.9	
175	Other OR therapeutic procedures on skin and breast	376,101	330,690	394,619	394,545	-12.1	19.3	0.0	
225	Conversion of cardiac rhythm	169,206	158,750	201,665	225,417	-6.2	27.0	11.8	Increase in volume from 2020-2021 may reflect increasing use of ambulatory surgery for this type of procedure.
244	Gastric bypass and volume Reduction	24,658	25,629	38,402	43,851	3.9	49.8	14.2	Increase in volume from 2020-2021 may reflect increasing use of ambulatory surgery for this type of procedure.

Abbreviations: CMS, Centers for Medicare & Medicaid Services; CPT, Current Procedural Terminology; GI, gastrointestinal; NASS, Nationwide Ambulatory Surgery Sample; OR, operating room

^a See CMS Hospital Outpatient Prospective Payment- Notice of Final Rulemaking (NFRM) with Comment Period (CMS–1678–FC), available at: <https://www.govinfo.gov/content/pkg/FR-2017-11-13/pdf/2017-23932.pdf>.

Notes: Totals represent weighted estimates. CCS category totals are unduplicated, such that if two or more CPT codes on the same encounter record mapped to the same CCS category, the record was only counted once. Totals are missing if the CCS procedure category was not in scope for the NASS sample. Contributing reasons for changes over time are reported only for categories that were added to or removed from the NASS in-scope procedure list and for categories with year-to-year percentage change in volume greater than 20 percent.