CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2819	**Date: November 19, 2013**
	Change Request 8421

Transmittal 2778, dated August 30, 2013, is being rescinded and replaced by Transmittal 2819, dated November 19, 2013, to revise the FY 2014 Total Uncompensated Care Amount, correct the year in the last sentence of the second paragraph in the Low Volume section and to correct the HRR Participant field input value in the Provider Specific File when the readmissions adjustment factor on Table 15 is equal to 1.0000. Also, since all legacy contractors have now transitioned to MACs, FIs and Carriers have been unchecked from the business requirements. All other information remains the same.

SUBJECT: Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2014 update to the IPPS and LTCH PPS. Internet Only Manual updates are incorporated within this Recurring Notification. This Recurring Update Notification applies to chapter 3, section 20.2.3.1**.**

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20.2.3.1/Provider Specific File

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2819	Date: November 19, 2013	Change Request: 8421

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) outlines changes to the Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Prospective Payment Systems (PPS) for Long Term Care Hospitals (LTCHs) for FY 2014. The policy changes for FY 2014 were displayed in the Federal Register on August 02, 2013, with an anticipated publication date of August 19, 2013. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2013, unless otherwise noted.

B. Policy:

IPPS FY 2014 Update

The FY 2014 IPPS Pricer is released to the FISS for discharges occurring on or after October 1, 2013. Refer to Table 1 for the FY 2014 IPPS Rates and Factors in the Attachment titled, "FY 2014 Tables".

MS-DRG Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed new MS-DRG Grouper, Version 31.0, software package effective for discharges on or after October 1, 2013. The GROUPER assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). Please note the National Uniform Billing Committee (NUBC) approved 15 new patient discharge codes (81-95) adapted after existing codes with “a Planned Acute Care Hospital Inpatient Readmission” appended in the title. A new patient discharge status code 69 was created in order for providers to be able to indicate discharges/transfers to a Designated Disaster Alternative Care Site. The MCE Version 31.0 which is also developed by 3M-HIS, uses the ICD-9-CM codes to validate coding for discharges on or after October 1, 2013.

For discharges occurring on or after October 1, 2013, the Fiscal Intermediary Standard System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation in early August 2013.

For discharges occurring on or after October 1, 2013, the MCE selects the proper internal tables based on discharge date. Medicare contractors should have received the MCE documentation in early August 2013.

NOTE: The version continues to match the Grouper.

Post-acute Transfer and Special Payment Policy

There are no changes to the Post-acute and Special Post-acute payment policy or applicable DRGs for FY 2014. See Table 5 of the FY 2014 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs. Click on the following link:http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Then click on the link on the left side of the screen titled, "FY 2014 IPPS Final Rule Home Page" or "Acute Inpatient‐‐Files for Download".

The new patient "Planned Readmissions" discharge codes (81-95) mentioned above in the MS-DRG Grouper and Medicare Code Editor (MCE) Changes section have been mapped to their non-planned readmission counterparts and will be included in the transfer policy. CWF edits have been updated with the new discharge codes as necessary.

New Technology Add-On

The following items are eligible for new-technology add-on payments in FY 2014:

1. DIFICID- Cases involving DIFICID that are eligible for the new technology add-on payment will be identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is $868. (For your information the ICD-10-CM diagnosis code is A04.7.)

2. Zenith Fenestrated Graft- Cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50. (For your information the ICD-10-CM procedure codes are: 04U03JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Approach; 04U04JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach; 04V03DZ -Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach or 04V04DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Endoscopic Approach.)

3. Voraxaze- Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of Glucarpidase into Peripheral Vein, Percutaneous Approach or 3E043GQ - Introduction of Glucarpidase into Central Vein, Percutaneous Approach.)

4. New for FY 2014 - Argus- Cases involving the Argus ®II System that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 14.81. The maximum add-on payment for a case involving the Argus ®II System is $72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach or 08H105Z - Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach.)

5. New for FY 2014 - Kcentra- Cases involving Kcentra that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is $1,587.50. DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM: 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.7, 286.52, 286.53, 286.59. (For your information the ICD-10-CM procedure codes are: 30280B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach or 30283B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312,

D68.318, D68.32 and D68.4.)

6. New for FY 2014 - Zilver- Cases involving the Zilver® PTX® that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 00.60. The maximum add-on payment for a case of the Zilver® PTX® is $1,705.25. (For your information the ICD-10-CM procedure codes are: 047K04Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047K34Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach; 047K44Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach; 047L04Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047L34Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach or 047L44Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach.)

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2013, can be found in the FY 2014 IPPS/LTCH PPS final rule and is also displayed in Table 2 in the Attachment titled, "FY 2014 Tables".

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A - Section 505, shows the IPPS providers that will be receiving a "special" wage index for FY 2014 (i.e., receive an out-commuting adjustment under section 505 of the MMA). For any provider with Special Wage Index from FY 2013, FIs and A/B MACs shall remove that special wage index by entering zeros in the field unless they receive a new special wage index as listed in this attachment.

Treatment of Certain Providers Re-designated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which re-designates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are re-designated. To ensure these hospitals counties (commonly referred to as “Lugar hospitals”) are paid correctly under the IPPS, FIs and A/B MACs shall enter the urban Core Based Statistical Area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF, except for hospitals that waive Lugar re-designation for the out-migration adjustment (as discussed below in this instruction). (**NOTE:** this may be different from the urban CBSA in the wage index CBSA field on the PSF for Lugar hospitals that are reclassified for wage index purposes.)

A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. Refer to Table 3 in the Attachment titled, "FY 2014 Tables" for a list of Lugar hospitals that accepted the out-migration adjustment and are therefore rural for all IPPS purposes for FY 2014. (**NOTE**: this may be different from the CBSA in the wage index CBSA field on the PSF for such hospitals that are reclassified for wage index purposes.)

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103

An urban hospital that reclassifies as a rural hospital under §412.103 is considered rural for all IPPS purposes. The FIs and A/B MACs shall enter the rural CBSA (2-digit State code) in the standardized amount CBSA field on the PSF rather than the urban CBSA corresponding to their actual location to ensure correct payment under the IPPS**.** **NOTE**: hospitals reclassified as rural under §412.103 are not eligible for the

capital DSH adjustment since these hospitals are considered rural under the capital PPS (see §412.320(a)(1)). Please reference Table 9C of FY 2014 Final rule.

Hospital Specific (HSP) Rate Update for Sole Community Hospitals (SCHs)

For FY 2013, Medicare contractors updated the Hospital Specific (HSP) amount in the PSF for all SCHs to FY 2012 dollars. For FY 2014, HSP amount in the PSF will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond.

NOTE: under current law the MDH program expires to the end of FY 2013 (that is, for discharges occurring before October 1, 2013), and therefore it is not necessary to update the HSP amount in the PSF for MDHs for FY 2014.

In addition, the HSP logic in Pricer has been updated, consistent with the implementation of the statutory changes to the operating DSH payment methodology provided by the provisions of section 3133 of the Affordable Care Act, to include the empirically justified DSH payment and the estimated uncompensated care payment in the Federal rate payment amount, if applicable, when comparing the HSP rate payment amount to the Federal rate payment amount.

Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration

The special payment protections provided to a Medicare dependent small rural hospital (MDH) are not authorized by statute beyond FY 2013. Therefore, beginning in FY 2014, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the Federal rate. (We note that, our SCH policy at §412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 are no longer valid beginning in FY 2014, and contractors shall update the PSF accordingly to reflect the appropriate provider type with an effective date of October 1, 2013.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2014

For FYs 2011, 2012, and 2013, the Affordable Care Act, as amended by the American Tax Relief Act, expanded the definition of a low volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Beginning with FY 2014, the low volume hospital definition and payment adjustment will revert to the policies that were in effect prior to the amendments made by the Affordable Care Act and the American Tax Relief Act. Therefore, as specified under the regulations at § 412.101, effective for FY 2014 and subsequent years, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another "subsection (d) hospital" and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2014 and subsequent years, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

The FI/MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The FI/MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria. For FY 2014 (and subsequent years), the FI/MAC makes the discharge determination based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges. The hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume hospital payment adjustment for the current year (see § 412.101(b)(2)(i)). To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2014 (and subsequent years), a hospital must be located more than 25 road miles (as defined at § 412.101(a)) from the nearest "subsection (d) hospital" (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its FI/ MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The FI/ MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the FI/ MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In order to receive the low-volume hospital payment adjustment for FY 2014, a hospital must meet both the discharge and mileage criteria (set forth at §412.101(b)(2)(i)).

For FY 2014, a hospital should make its request for low-volume hospital status in writing to its FI/MAC and provide documentation that it meets the mileage criterion by September 1, 2013, so that the 25 percent low-volume hospital adjustment can be applied to payments for its discharges occurring on or after October 1, 2013, (through September 30, 2014). For requests for low-volume hospital status for FY 2014 received after September 1, 2013, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the 25 percent low-volume hospital adjustment in determining payments to the hospital's FY 2014 discharges prospectively within 30 days of the date of the FI's/MAC's low-volume hospital status determination.

The FI/MAC is to notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as low-volume hospitals and the effective date of the determinations for FY 2014 by November 9, 2013. The notification may be sent via e-mail to Michele.Hudson@cms.hhs.gov and Maria.Navarro@cms.hhs.gov, and should include the hospital's name, CMS certification number (CCN), address (street, city, state and zip code), the number of total discharges and begin and end dates from the hospital's most recently submitted cost report, the distance to the nearest IPPS hospital (as well as that hospital's address: street, city, state and zip code) by which the hospital qualified for low-volume status, and the effective date of the low-volume hospital determination. For low-volume hospital requests received after September 1, 2013, FIs/MACs shall notify CMS Central Office as above within 15 days of the determination.

For discharges occurring during FY 2013, if a hospital qualifies as a low volume hospital, the existing low-volume indicator field on the PSF (position 74 – temporary relief indicator) would display a value of 'Y'. In order to implement this policy for FY 2014, the Pricer will apply the 25 percent low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF. If a hospital qualified for the low-volume hospital payment adjustment in FY 2013 but no longer meets the low-volume hospital definition for FY 2014 (that is, does not meet either the discharge or mileage criteria in 412.101(b)(2)(i)), and therefore, the hospital is no longer eligible to receive a low-volume hospital payment adjustment in FY 2014,the FI/MAC must update the low-volume indicator field on the PSF (position 74 - temporary relief indicator) to hold a value of 'blank'.

The 25 percent low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), IME and outliers. For SCHs, the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following Web site: www.qualitynet.org. This Web site is expected to be updated by August 19, 2013. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site, and FIs and A/B MACs shall update the provider file as needed. A list of hospitals that will receive the 2.0 percent reduction to the annual payment update for FY 2014 under the Hospital Inpatient Quality Reporting (IQR) Program are listed in Attachment C - Hospitals Not Receiving Annual Payment Update (APU) - FY 2014 of this CR.

For new hospitals, FIs and A/B MACs shall enter a '1' in the PSF and provide information to the Quality Improvement Organization (QIO) as soon as possible so that the QIO can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative. The FIs and A/B MACs shall provide this information monthly to the QIO in the State in which the hospital has opened. It shall include the following:

• State Code

• Medicare Accept Date

• Provider Name

• Contact Name (if available)

• Provider ID number

• Telephone Number

Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. CMS has excluded Maryland hospitals from the Hospital VBP Program for the FY 2014 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.160 through §412.162).

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute .The applicable percent for payment reductions for FY 2014 is 1.25 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS calculates a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSes and submit requests for corrections to the information before it is made public.

For FY 2014 CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2014. CMS will provide the claims processing contractors with a file containing the value-based incentive payment adjustment factors via Technical Direction Letter (TDL).

Upon receipt of this file, the claims processing contractors must update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of 'Y' if the provider is included in the Hospital VBP Program and the claims processing contractors must update the Hospital VBP Program adjustment field (VBP Adjustment) to input the value-based incentive payment adjustment factor, according to the timeframe included in the forthcoming TDL. **NOTE:** The values listed in Table 16A of the IPPS/LTCH PPS Final Rule are **proxy values**. These values are not to be used to adjust payments. Until CMS issues final values, contractors shall enter 'N' in the VBP Participant field.

The IPPS PRICER will display the VBP payment amount in a new output field.

Hospital Readmissions Reduction Program

For FY 2014, the readmissions adjustment factor is the higher of a ratio or 0.98 (-2 percent). The readmission adjustment factor is applied to a hospital's "base operating DRG payment amount", or the wage adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions. Add-on payments for IME, DSH (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2014 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2014, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9800.

The Hospital Readmissions Reduction Program participant (HRR Participant) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF must be updated by the FI/MAC with an effective date of October 1, 2013. The Hospital Readmissions Reduction Program adjustment factors for FY 2014 can be found in Table 15 of the FY 2014 IPPS final rule, which is available on the Internet at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html?DLPage=1&DLSort=0&DLSortDir=ascending.

• If a provider has a readmissions adjustment factor on Table 15 that is equal to 1.0000, then Medicare contractors shall input a value of '1' in the HRR Participant field and enter 1.0000 in the HRR Adjustment field.

• If a provider has a readmissions adjustment factor on Table 15 that is less than 1.0000, then Medicare contractors shall input a value of '1' in the HRR Participant field and the readmissions adjustment factor in Table 15 into the HRR Adjustment field.

• If a provider is not listed on Table 15, then Medicare contractors shall input a value of '0' in the HRR Participant field and leave the HRR Adjustment field blank.

NOTE: Although Maryland hospitals are exempt from the payment adjustment under the Hospital Readmissions Reduction Program for FY 2014, a readmissions adjustment factor of 1.0000 (that is no adjustment) is shown for Maryland hospitals in Table 15. Therefore, follow the instructions above for the PSF for Maryland hospitals.

Hospitals located in Puerto Rico are not subject to the Hospital Readmissions Reduction Program and therefore are not listed in Table 15. Therefore, follow the instructions above for the PSF for Puerto Rico hospitals.

The IPPS PRICER will display the HRR payment amount in a new output field.

Recalled Devices

As a reminder, section 2202.4 of the Provider Reimbursement Manual, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

Bundled Payments for Care Improvement Initiative (BPCI)

Model 1 - CMS is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative. In Model 1, the episode of care is defined as the acute care hospital stay only. Applicants for this model propose a discount percentage which will be applied to payment for all participating hospitals' Diagnosis Related Groups (DRG) over the lifetime of the initiative. Participating hospitals may gain share with physicians any internal hospital savings achieved from redesigning care if they can reduce hospital costs for the episode below the discount provided to CMS as part of their agreement. More information may be found at: http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html.

For hospitals participating in Model 1 of the BPCI, a standard discount will be taken from all DRG payments made to the hospital. The discount will be phased in over time, with the discount amount updated as frequently as every six months. This adjustment will be made to the base operating DRG (as defined earlier in this change request). IME, DSH, and outlier payments will be calculated based on the non-discounted base payments. PRICER will display the Model 1 payment amount in a new output field.

Medicare Contractors shall refer to Attachment B - Model 1 Participants to update their provider records to include a value of '1' for the participants listed and the BPCI Model 1 discount percentage.

Internally, the claims processing system will convert the Model 1 participating indicator '1' to a demo code '61' which will trigger PRICER to perform the payment calculation using the discount percentage.

Model 1 demonstration code '61' is for internal use only and shall not be entered by providers.

Provider Specific File (PSF)

The PSF-required data elements for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, but you must update all applicable fields for IPPS hospitals effective October 1, 2013, or effective with cost reporting periods that begin on or after October 1, 2013, or upon receipt of an as-filed (tentatively) settled cost report. Pricer requires a PSF record with a 10/1 effective date.

Tables 8a and 8b contain the FY 2014 Statewide average operating and capital cost-to-charge ratios, respectively. To access Tables 8a and 8b click on the following link: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. On the left side select FY 2014 IPPS Final Rule Home Page and then select FY 2014 Final Rule Tables.

Per the regulations at 42 CFR section 412.84(i)(3), for FY 2014, Statewide average CCRs are used in the following instances: 1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18). 2. Hospitals whose operating CCR is in excess 1.186 or capital CCR is in excess of 0.173 (referred to as the operating CCR ceiling and capital CCR ceiling, respectively). 3. Hospitals for which the FI or MAC is unable to obtain accurate data with which to calculate an operating and/or capital CCR. **NOTE:** Hospitals, FIs and Medicare contractors can request an

alternative CCR to the statewide average CCR per the instructions in section 20.1.2 of chapter 3 of the claims processing manual. Provider Types (PSF data element 9) 14 and 15 are no longer valid beginning in FY 2014 (with the expiration of the MDH program as noted above). Contractors shall determine the appropriate provider type and update the PSF accordingly with an effective date of October 1, 2013.

Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, hospitals will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital's share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

The Medicare DSH payment will be reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment will be applied in PRICER.

For FY 2014, the total uncompensated care payment amount to be paid to Medicare DSH hospitals is $9,044,632,555.68, as calculated as the product of 75 percent of Medicare DSH (estimated CMS Office of the Actuary) and the change in percent of uninsured individuals at 94.3 percent. The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2014 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2014. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY2010-2012). The estimated per discharge uncompensated care payment amount will be in a Table in PRICER and that dollar amount will be added to each claim for FY 2014. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations, and will be included as a federal payment in the comparison for Sole Community Hospitals to determine if a claim is paid under the hospital specific rate or federal rate. The total uncompensated care payment amount finalized in the FY 2014 IPPS Final Rule will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

The IPPS PRICER will display the uncompensated care payment amount in a new output field.

LTCH PPS FY 2013 Update

FY 2014 LTCH PPS Rates and Factors are located in Table 4 in the attachment titled, "FY 2014 Tables".

The LTCH PPS Pricer has been updated with the Version 31.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2013, and on or before September 30, 2014.

LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. Beginning in FY 2014, the annual update to a standard Federal rate will be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance

with the LTCHQR Program for that year. MACs will receive more information under separate cover.

Provider Specific File (PSF)

The PSF-required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update all applicable fields for LTCHs effective October 1, 2013, or effective with cost reporting periods that begin on or after October 1, 2013, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8c contains the FY 2014 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost outlier payments. Table 8c is available on the internet at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1599-F.html. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2014, Statewide average CCRs are used in the following instances: 1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18). 2. LTCHS with a total CCR is in excess of 1.305 (referred to as the total CCR ceiling). 3. Any hospital for which data to calculate a CCR is not available**.** **NOTE**: Hospitals, FIs and Medicare contractors can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the claims processing manual.

Cost of Living Adjustment (COLA) Update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The applicable COLAs that are effective for discharges occurring on or after October 1, 2013, established in the FY 2014 IPPS/LTCH PPS final rule, are shown in Table 2 in the Attachment titled, "FY 2014 Tables".

Core-Based Statistical Area (CBSA)-based Labor Market Area Updates

There are no changes to the Core-Based Statistical Area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2014. The CBSAs definitions and codes that will continue to be effective October 1, 2013, can be found in Table 12A listed in the Addendum of the FY 2014 IPPS/LTCH PPS final rule, which is available on our Web site.

Additional LTCH PPS Policy Changes for FY 2014

The moratoria on the full implementation of the "25 percent threshold" payment adjustment will expire for LTCH cost reporting periods beginning on or after October 1, 2013. (The 5 year statutory moratorium which expired for cost reporting periods beginning on or after July 1 or October 1, 2012, as applicable, was followed by regulatory moratoria that generally maintained the existing policies for both "July" and "October" LTCHs. For additional details, refer to the discussion in the FY 2014 IPPS/LTCH PPS final rule.

In addition, the short-stay outlier (SSO) logic in the PRICER was updated to reflect the implementation of the statutory changes to the IPPS operating DSH payment methodology provided by the provisions of section 3133 of the Affordable Care Act in the calculation of "an amount comparable to the IPPS per diem amount" under the 4th option in the SSO payment formula.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility

		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8421.1	FISS shall install and pay claims with the FY 2014 IPPS Pricer for discharges on or after October 1, 2013.								X				
8421.2	FISS shall install and pay claims with the FY 2014 LTCH Pricer for discharges on or after October 1, 2013.								X				
8421.3	FISS shall install and edit claims with the MCE version 31.0 and Grouper version 31.0 software with the implementation of the FY 2014 October quarterly release.								X				
8421.4	FISS shall establish yearly recurring hours to allow for updates to the list of ICD-9-CM diagnosis codes that are exempt from reporting Present on Admission (POA). **NOTE:** There are no changes to the list of ICD-9-CM diagnosis codes exempt from reporting POA.								X				
8421.5	Medicare contractors shall inform the QIO of any new hospital that has opened for hospital quality purposes.	X											
8421.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 9, 2013.	X											
8421.6.1	Medicare contractors shall update the PSF for CBSA and special wage index changes per the policy sections of this CR.	X											
8421.7	Medicare contractors shall notify CMS Central Office - Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as a low-volume hospital and the effective date of the determination for discharges **occurring in FY 2014 by November 9, 2013**. Contractors shall also notify CMS Central Office - Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro of IPPS hospitals qualified as low-volume hospitals after September 1, 2013, within 15 days of the determination.	X											
8421.7.1	Medicare contractors shall remove the 'Y' low-volume indicator in the PSF (position 74 - temporary relief indicator) for providers who no	X											

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	longer qualify as a low volume provider. .												
8421.8	Medicare contractors shall be aware of the manual updates included within this CR.	X											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8421.9	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@cms.hhs.gov , Sarah Shirey-Losso, sarah.shirey-losso@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachments (4)

Table 1--FY 2014 IPPS Rates and Factors

Standardized Amount Applicable Percentage Increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
Hospital Specific Applicable Percentage Increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
Common Fixed Loss Cost Outlier Threshold	$21.748.00
Federal Capital Rate	$429.31
Puerto Rico Capital Rate	$209.82
Outlier Offset-Operating National	0.948995
Outlier Offset-Operating Puerto Rico	0.943455
SCH Budget Neutrality Factor	0.997989
SCH Documentation and Coding Adjustment Factor	0.9480
Adjustment to Offset the Cost of the Policy on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A	0.998

Operating Rates

Rates with Full Market Basket and Wage Index > 1	
National Labor Share	$3,737.71
National Non Labor Share	$1,632.57
PR National Labor Share	$3,737.71
PR National Non Labor Share	$1,632.57
Puerto Rico Specific Labor Share	$1,608.90
Puerto Rico Specific Non Labor Share	$936.82
Rates with Full Market Basket and Wage Index < or = 1	
National Labor Share	$3,329.57
National Non Labor Share	$2,040.71
PR National Labor Share	$3,329.57

PR National Non Labor Share	$2,040.71
Puerto Rico Specific Labor Share	$1,578.35
Puerto Rico Specific Non Labor Share	$967.37
Rates with Reduced Market Basket and Wage Index > 1	
National Labor Share	$3,664.21
National Non Labor Share	$1,600.46
PR National Labor Share	$3,737.71
PR National Non Labor Share	$1,632.57
Puerto Rico Specific Labor Share	$1,608.90
Puerto Rico Specific Non Labor Share	$936.82
Rates with Reduced Market Basket and Wage Index < or = 1	
National and PR National Labor Share	$3,264.10
National and PR National Non Labor Share	$2,000.57
PR National Labor Share	$3,329.57
PR National Non Labor Share	$2,040.71
Puerto Rico Specific Labor Share	$1,578.35
Puerto Rico Specific Non Labor Share	$967.37

Table 2: FY 2014 Cost-of-Living Adjustment Factors: Alaska and Hawaii Hospitals

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25

Area	Cost of Living Adjustment Factor
County of Maui and County of Kalawao	1.25

Table 3- Hospitals Waiving Lugar Redesignation for the Out-Migration Adjustment

Medicare CCN	Provider Name
070021	WINDHAM COMM MEM HOSP & HATCH HOSP
250117	HIGHLAND COMMUNITY HOSPITAL
390031	SCHUYLKILL MEDICAL CENTER - EAST NORWEGIAN STREET
390150	SOUTHWEST REGIONAL MEDICAL CENTER
390201	POCONO MEDICAL CENTER

Table 4- Hospital-Specific (HSP) Rate Update for Sole Community Hospitals (SCHs)

Hospital Specific Applicable Percentage Increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
SCH Budget Neutrality Factor	0.997989
SCH Documentation and Coding Adjustment Factor	0.9480
Adjustment to Offset the Cost of the Policy on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A	0.998

Table 5- FY 2014 LTCH PPS Rates and Factors

Federal Rate for discharges from 10/1/13 through 09/30/14	New beginning in FY 2014, rate based on successful reporting of quality data.

	• Full update (quality indicator on PSF = 1): $ 40,607.31 • Reduced update (quality indicator on PSF = 0 or blank): $ 39,808.74
Labor Share	62.537%
Non Labor Share	37.463%
High Cost Outlier Fixed-Loss Amount	$13,314

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 2819, Issued: 11-19-13)

Transmittals for Chapter 3

20.2.3.1 - Provider-Specific File

(Rev. 2819, Issued: 11-19-13, Effective: 10-01-13, Implementation: 10-07-13)

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. The FI maintains the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the FI prepares an additional record showing the effective date. For example, when a hospital's FY beginning date changes as a result of a change in ownership or other "good cause," the FI makes an additional record showing the effective date of the change.

The format and data required by the PRICER program and by the provider-specific file is found in Addendum A.

The FIs submit a file of provider-specific payment data to CMS CO every three months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), SNFs, and hospices, including those in Maryland. Regional home health FIs (RHHIs) submit a file of provider specific data for all home health agencies. FIs serving as the audit FI for hospital based HHAs do not submit a file of provider specific data for HHAs.

The FIs create a new record any time a change occurs for a provider. Data must be reported for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within seven business days after the end of the period being reported.

NOTE: FIs submit the latest available provider-specific data for the entire reporting period to CO by the seven-business day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period, the FI may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, the FI may exclude the October 1 CO-required changes from the file submitted by October 9. The FI includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A. PPS Hospitals

The FIs submit all records (past and current) for all PPS providers every three months. Duplicate the provider file used in the "PRICER" module of the claims processing system.

B. Non-PPS Hospitals and Exempt Units

The FIs create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every three months. Code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file.

C. Hospice

The FIs create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all hospices. Data elements 33 and 38 are optional and may be populated if needed.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

D. Skilled Nursing Facility (SNF)

The FIs create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998.
The FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all SNFs. Data elements 33 and 38 are required if there is a special wage index. Effective October 1, 2005, through September 30, 2006, data elements 33 and 38 are required since there is a special wage index.

E. Home Health Agency (HHA)

The FIs create a provider specific history file using the following data elements for each HHA. Regional home health FIs (RHHIs) submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

F. Inpatient Rehabilitation Facilities (IRFs)

The FIs create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 18, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all IRFs. Data elements 17, 33, 38, and 49 are required if applicable to the IRF.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

G. Long Term Care Hospital (LTCH)

The FIs create a provider specific history file using the following data elements for each LTCH beginning with their first cost reporting period that starts on or after October 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 18, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

Effective July 1, 2005, data element 35 is required. Data elements 33 and 38 are optional and may be populated if needed. Data elements 12, 13, and 14 are no longer applicable.

Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

H. Inpatient Psychiatric Facilities (IPF)

The FIs create a provider specific history file using the following data elements for each IPF beginning with their first cost reporting period that starts on or after January 1, 2005.

The FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 17, 18, 19, 21, 22, 23, 25, 33, 35, 38, and 48 are required. All other data elements are optional for this provider type. Although data element 25 refers to the operating cost to charge ratio, ensure that both operating and capital cost-to-charge ratio are entered in data element 25 for IPFs. Ensure that data element 21 (Facility Specific Rate) will be determined using the same methodology to determine the interim payment per discharge under the TEFRA system.

Effective July 1, 2006, data element 13 is no longer required. Data elements 33 and 38 are optional and may be populated if needed.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

NOTE: All data elements, whether required or optional, must have a default value of “0” (zero) if numerical, or a blank value if alphanumerical.

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. FIs must set up an NDM transfer from the FI's system for which it is responsible. It is critical that the provider specific data is copied to the CMS Data Center using the following input data set names ("99999" should be changed to the FI's 5-digit number):

Data set Name ---COPY TO: --MU00.@FPA2175.intermediary99999

DCB=(HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)

Data set Name ---RUN JOB: --MU00.@FPA2175.CLIST(intermediary99999)

See **Addendum A** for the Provider Specific File record layout and description.